Integrated Community Case Management (iCCM) Costing and Financing Tool

Implementation Manual & Tool User Guide

Version 1.0

Management Sciences for Health

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Comments and questions on the iCCM Costing and Financing Tool should be directed to fintools@msh.org.

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For more information about the iCCM Costing and Financing Tool, visit:

www.tractionproject.org/costing-iccm

www.msh.org/iccm

Comments and questions on the iCCM Costing and Financing Tool should be directed to:

fintools@msh.org

Acronym List

ACT	artemisinin-combination therapies
ARI	acute respiratory infection
ASC	*agent de santé communautaire* (community health worker)
BCC	behavior change communication
CHW	community health worker
C-IMCI	Community-Based Integrated Management of Childhood Illness
DHO	district health office
DHS	Demographic Health Survey
GHI	Global Health Initiative
HMIS	Health Management Information System
iCCM	integrated community case management
IMCI	Integrated Management of Childhood Illness
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MOH	Ministry of Health
MOHP	Ministry of Health and Prevention
MSH	Management Sciences for Health
MUAC	mid-upper arm circumference
NGO	non-governmental organization
ORS	oral rehydration salts
RDT	rapid diagnostic test
TB	tuberculosis
TRAction	Translating Research into Action, project funded by USAID
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USAID	US Agency for International Development
WHO	World Health Organization

Introduction

Welcome to the Integrated Community Case Management (iCCM) Costing and Financing Tool. Management Sciences for Health (MSH), through a sub-grant from University Research Council (URC), LLC's TRAction Project, has developed a spreadsheet-based and user-friendly tool to assess the costs of integrated community case management (iCCM) programs. The iCCM Costing and Financing Tool allows users to calculate the costs and financing elements linked to all elements of the vertical iCCM program, including service delivery, training, supervision, and management from community to central levels.

This implementation manual and tool user guide will provide program planners and managers with in-depth instructions to using the iCCM Costing and Financing tool. The tool is customizable tool and can be used to assess the costs and financing of iCCM Program introduction and expansion in developing country settings, with different levels of iCCM experience. The tool can be used to calculate costs and financing requirements for the iCCM program baseline year, as well as for five projection years.

This iCCM tool can be customized to your program or country context and covers all aspects of the iCCM program, comprising start-up costs, training costs, community level service delivery costs, as well as support, supervision, and management costs at all levels of the health system. Additionally, the tool has a financing element that can be used to show and program financing sources and show gaps in funding. The iCCM tool is based in Excel and is open access, allowing the user to see all calculations and results in the model.

Most iCCM programs comprise three key intervention areas – pneumonia, diarrhea, and malaria – but the iCCM tool has the ability to include up to ten interventions. At the service delivery level, it is a bottom-up activity-based costing tool, in which unit costs per service are built up by type of resource (such as medicines) and multiplied by the total estimated numbers of services. Other costs, such as supervision and training, are allocated using a top-down methodology. The tool uses standard treatment protocols for the iCCM services to determine the standard costs of treatment.

This tool automatically produces the following outputs used to measure cost efficiency and effectiveness:

- Total program costs, baseline year and five-year cost projections;
- Costs per capita, per CHW, per contact, per disease type and per resource type;
- Incremental costs and incremental financing of the iCCM programs (start-up and recurrent) as a whole and for each level (national, regional, district, facility and community) over time;
- Costs per treatment area (pneumonia, diarrhea, malaria, etc.), with the capability to include other iCCM interventions;
- Key drivers of costs and cost categories as a percent of total costs; and
- Five-year projections of financing with sources of funding.

The iCCM tool can be used for the following analyses:

- Measure cost efficiency and effectiveness of different program options, such as scaling-up;
- Plan and budget a new iCCM program or expand an existing one;
- Produce global and country financial iCCM indicators, as developed by the iCCM technical advisory group;
- Develop "What-if" scenarios that were considered by researchers or program managers to improve program sustainability or to reduce funding requirements;
- Lobby for support (funding and otherwise) from donors and partners;

This User and Implementation Manual is accompanied by two versions of the iCCM tool: 1) a blank version of the tool, to input all relevant assumptions and information regarding your country program (iCCM_Costing_and_Financing_Tool_Version1.0); and 2) a demo version of the tool, with sample country data included for your reference (iCCM_Costing_and_Financing_Tool_Version1.0_demo).

Section 1: Implementation Manual describes the methodology for conducting an iCCM costing and financing analysis, and potential applications of the results.

Section II: Tool User Guide provides detailed step-by-step instructions on how to enter data into the iCCM Costing and Financing Tool.

The iCCM Costing and Financing Tool requires a detailed level of data to estimate the costs and financing needs of iCCM programs as accurately as possible. The tool was designed specifically for iCCM program managers and planners, and can be adapted to each individual country and program context. As a result, there are numerous data requirements that the user must enter. The authors recommend a thorough review of this document prior to starting any data entry or analysis with the tool.

Background

Integrated community case management (iCCM) has proven to be an effective strategy for expanding the provision of diarrhea, pneumonia, and malaria services and is accepted as a key strategy to meet Millennium Development Goal 4 (MDG) by international donors and developing countries. The evidence indicates that a well-implemented community health workforce can improve health seeking behaviors and provide low-cost interventions for common maternal and child health issues, while enabling improvements in the continuum of care. Furthermore, it is a pivotal strategy to achieving the Global Health Initiative (GHI) vision.

Diarrhea, malaria, and pneumonia are leading causes of child mortality and are the result of nearly 44% of deaths worldwide in children under five. As an effective strategy to deliver lifesaving interventions for these illnesses, iCCM is promoted by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United States Agency for International Development (USAID), and the GHI. Several developing countries have adopted and promoted policies and programs in which community health workers (CHWs) promote timely and low-cost care by treating uncomplicated cases of diarrhea, pneumonia, and malaria and referring severe cases to health facilities.

A meta-analysis of nine studies found that iCCM of pneumonia reduced overall mortality in children 0-4 years by 24% (95% confidence interval, CI: 14-33) and pneumonia-specific mortality in children 0-4 years by 36% (95% CI: 20-49)[1]. In 2002, the WHO reviewed these and other findings and their response called for the national health authorities, WHO, UNICEF, and nongovernmental organizations (NGOs) to support implementation of the iCCM of pneumonia. Despite the success of this strategy in several low-income countries, iCCM programs in many other countries have yet to be implemented or expanded. This is partly due to concern or uncertainty about the costs and financing of iCCM programs. However, iCCM programs can be a cost-effective way to deliver healthcare to underserved populations with limited access to formalized health structures.

A comprehensive understanding of costs and financing will help countries considering implementing or expanding programs to advocate to donors and ministries of finance for necessary funding and to allocate sufficient funds to appropriate levels of the health system. It will also allow for costs to be better monitored and controlled, thus ensuring efficient use of scarce resources.

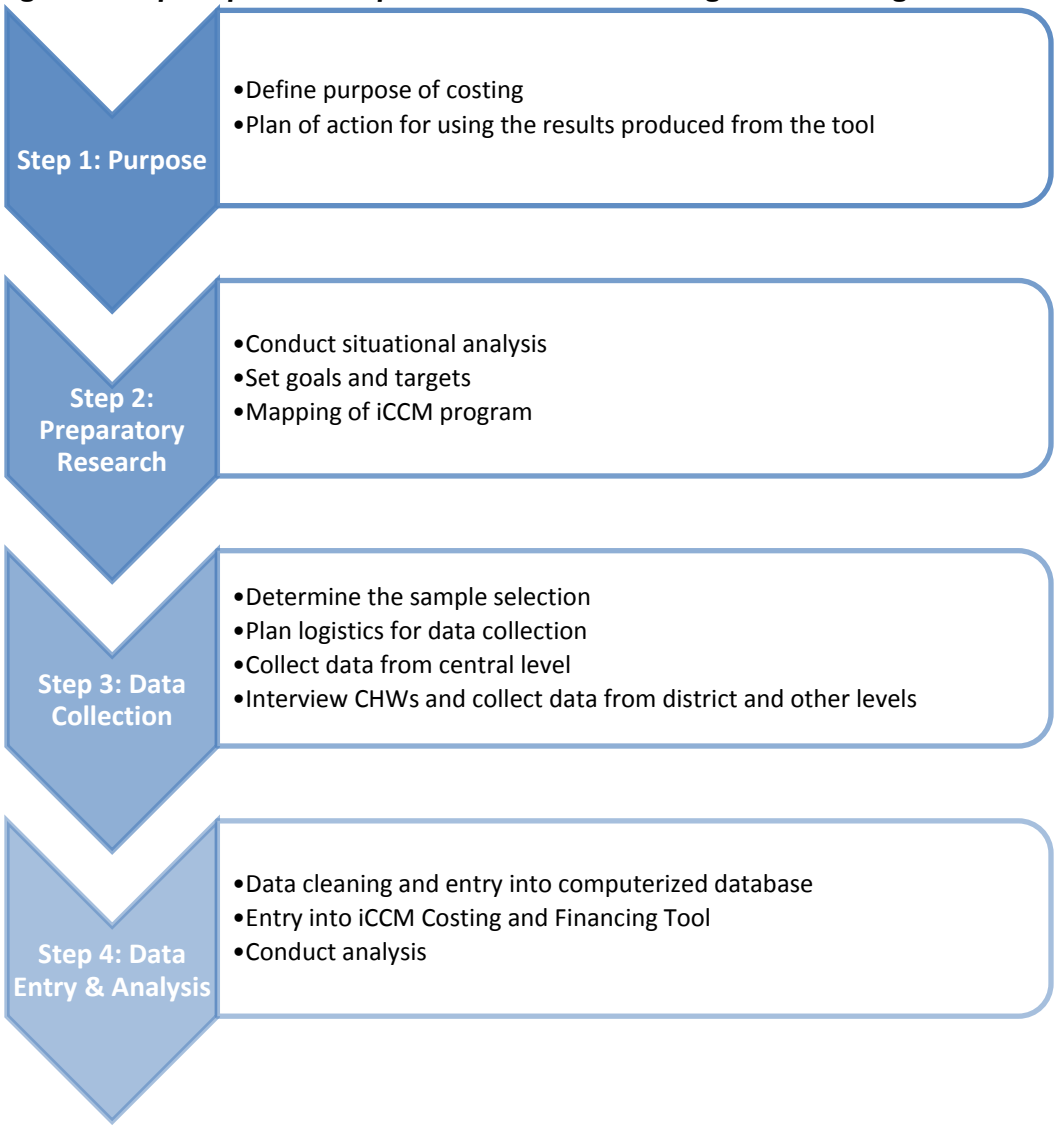
[1]Sazawal S, Black RE. Effect of pneumonia case management on mortality in neonates, infants, and preschool children: a meta-analysis of community-based trials. Lancet Infect Dis 2003;3:547-56. PMID:12954560 doi:10.1016/S1473-3099(03)00737-010.1016/S1473-3099(03)00737-0

Section I: Implementation Manual

The iCCM Costing and Financing tool provides a detailed and comprehensive method of assessing the costs of an iCCM program over six years – a baseline year and five projection years. Before beginning the analysis, the purpose of conducting the costing study should be clearly determined. This implementation manual will walk the user through key questions that should be asked before starting the costing exercise, as well as provide detailed information about how the costing should be conducted, what types of data are required, and suggestions for how and where to collect the data.

The following diagram outlines the main steps required to conduct a study using the iCCM Costing and Financing Tool: 1) define purpose of costing, 2) conduct preparatory research, 3) data collection, and 4) data entry and analysis. These steps are described in further detail in this section of the document.

Figure 1. Steps required to implement the iCCM Costing and Financing Tool



1. Purpose of iCCM Costing

Determining the purpose of the costing study is an essential first step to iCCM costing. This can be done by addressing important questions about the iCCM program, including the following:

- What is the current stage of iCCM implementation in the country? Is it in pilot phase, or a mature program, or has it not even begun implementation yet?
- What populations are being targeted by the iCCM program? Hard to reach areas? How are these defined?
- What is the current geographic coverage of the program?
- Will there be an expansion of the program into additional geographic areas? If so, what are the targets for geographical expansion?
- What is the current level of service delivery at the community compared with facility?
- What is target level of service delivery at the community level?
- What are the current services offered in the iCCM package?
- Which services, if any, should be added to the package?
- Who is financing the iCCM program?
- What is the scope of the costing exercise – a national level costing of the entire program, a district level costing of a pilot program, etc.?

In addition, the user should lay out a clear plan of action for using the results produced from the tool. With whom will the results be shared? Will the results be used for planning and budgeting purposes? To determine the cost of scaling up a program? To assess the cost effectiveness of delivering services at the community level versus facility? Will it be used for advocacy efforts, or planning purposes? These types of questions will allow the user to further define the information needed, and aid in the analysis.

If there is no current iCCM program in place, the costing and data collection will need to be entirely based on standards (this will be described in greater detail under Parts 3 and 4: Data Collection). In this case, the user should be prepared to provide assumptions for costs of medicines, salaries, per diems, trainings, and other program costs.

If there is a current iCCM pilot or program in place, the actual costs from this program can be used as a basis to make projections of future costs. For example, the current actual unit cost of an ACT treatment for malaria will be multiplied by the projected number of malaria treatments for each year. The actual cost of training a CHW to provide iCCM will be multiplied by the additional number of CHWs that will need to be trained to scale up the program.

2. Preparatory research

Once the purpose of the tool is laid out, certain aspects of the country's health system and iCCM program should be researched and understood in advance of the data collection.

Situational Analysis

The user should collect and review all possible policy and guideline documents related to iCCM within the country, as well as key international documents (e.g., from the World Health

Organization). These documents will help guide the data collection process and enable the user to more accurately utilize the iCCM Costing & Financing Tool. If no information on iCCM exists within the country (as may be the case in countries who have not implemented an iCCM program yet), the user should review the key international guidelines and policies regarding iCCM. Documents on the current state of child health should be collected, such as the latest Demographic Health Survey.

Mapping

Mapping of the country's current iCCM program should be done prior to the field visit. The user should understand and lay out the following:

- What role does the MOH/central government play in the iCCM program?
- Where in the country is the iCCM program currently being implemented?
- What NGOs and implementing partners are involved?
- What are the key sources of funding, and what specific program elements do they fund?
- Is iCCM program implementation uniform across districts, or does it vary, depending on partner support?
- Do CHWs have the same roles and provide the same services according to a single standard, or does this vary by region or partner support?
- What levels of the health system are involved in supervising the iCCM program?
- Are there significant differences in the epidemiological profile of different parts of the country? Are there important seasonal variations?

For countries where iCCM has not yet been implemented, the answers to these questions should be determined as best as possible, based on what is planned.

3. Data collection

Annex A shows a checklist of the types of data required to conduct the costing analysis. The iCCM Costing and Financing Tool can be used based purely on standard assumptions, or using actual data collected from an existing iCCM program. The first option (we will call this the "standard assumptions" option) would typically be used for a country where there is currently no iCCM program. It can also be used for a country with an existing iCCM program. The tool user would need to determine standard cost assumptions (for example, costs of medicines, salary costs, per diems, training costs, management costs, etc.) and input these into the tool. There would also need to be standard assumptions of the tasks CHWs perform, iCCM treatments they provide, and how much of their time is spent on iCCM versus other activities. Data required for the "standard assumptions" option should be available at the central level, and based on national policies where possible.

The second option (we will call this the "actual costs" option) could be used in a country with a current iCCM program – it can be in any stage of implementation, from pilot phase to mature program. For the second option, the tool user would need to collect actual cost and program data from a variety of sources. The user would also need to conduct interviews with CHWs to determine what types of activities they perform, and how they spend their time. The analysis would end up using a mix of actual and standard information – for example, the actual cost of the training would be multiplied by the standard number of CHWs that would be required to

scale up the iCCM program or to achieve a national target. Data required for the "actual costs" option will need to be collected from the central level (for standard costs and assumptions); from the community level (for CHW time and availability); and from any other levels providing support or supervision to the iCCM program.

This section of the implementation manual primarily details the actions required for the "actual costs" option. Note that these instructions should be considered illustrative and will need to be adapted to each country and program context. The same considerations should be made for the "standard assumptions" option, but it will not be necessary to travel to the field and collect the data physically via questionnaires.

Central and partner level data collection

The iCCM program may be implemented by the Ministry of Health, by implementing NGO partners, or a combination of the two. This section describes the standard data that should be collected at the central level, and may require interviews with MOH staff, NGO staff, or both. First, review the data checklist in Annex A to determine which organization or ministry department is the most appropriate to request the data required. Next, conduct interviews and collect data from the relevant personnel using the questionnaires in Annex B. Alternatively, the data can be entered directly into the iCCM Costing and Financing Tool (the questionnaires in Annex B are derived from the data entry questions in the tool).

Typically, the following data are collected from the central level (MOH and implementing partners). It may be necessary to collect the same data from multiple sources.

- National Population, total population covered by iCCM Program
- Breakdown of population by age (newborns, infants, children <5)
- Interventions in iCCM package and standard treatment guidelines
- Source of financing and amounts of funding secured for iCCM program
- Number of CHWs currently providing iCCM services
- Number of iCCM cases treated
- Incidence rate for each iCCM service
- List of standard equipment provided to CHW and cost of equipment
- List of essential medicines provided to CHW and cost of medicines
- Standard CHW working hours, if applicable
- CHW Salary, if applicable
- Management costs: list of all staff providing iCCM program management, salaries, and time spent on iCCM
- Supervision costs: list of all staff providing supervision to CHWs, salaries, and time spent on iCCM
- Meeting costs: list of all meetings required for CHWs and supervisors, costs
- Training costs: list of all trainings required for CHWs (initial/pre-service training and refresher training), costs
- Any additional iCCM program recurrent costs (administrative costs, overheads)
- Start-up costs

District & Community Data

Data are collected from the district, sub-district and community levels when conducting an "actual costs" scenario. The primary objective in collecting this information is to provide a "reality check" of the iCCM program, to determine the actual structure of the program on the ground, including the activities and services provided by the CHW, the supervision structure, and the involvement of the sub-national levels in implementing the iCCM program.

Sample data collection questionnaires are shown in Annex C. These include several questionnaires: district level questionnaire (Annex C1), health center level questionnaire (Annex C2), CHW questionnaire (Annex C3), and CHW Time template (Annex C4). **Note: it is essential that these questionnaires are adapted to the country or program context.** The highlighted rows in the sample questionnaires indicate data that will be transferred to the iCCM Costing and Financing Tool. The remaining questions have been included to provide background and context for the program. These additional questions may be expanded upon or removed, depending on the purpose of the analysis and study objective.

The questionnaires should be applied to each district, health center, and CHW sampled (see section on sampling below).

Sampling Selection

The mapping conducted during the preparatory research phase should aid in determining the sample size selected for the data collection. This sampling will be used to interview CHWs and their supervisors at each level of the health system where relevant. For example, the CHWs may be directly supervised by the Health Center In-Charge, but also receive periodic supervision visits from the District Health Office Community Health Officer. In this case, we would interview the CHW, the In-Charge, and the Community Health Officer to determine the extent of their involvement in the iCCM program.

The sample should be representative of the country and take into account geographic diversity and implementing partner diversity (if applicable), as well as iCCM program diversity (if applicable). In addition, any other criteria for sample selection should be identified prior to sample selection. For example, if one district in the country has been piloting RDTs for malaria, this district should be included in the sample. All relevant MOH and implementing partner staff should be consulted to help guide the sample selection, as they may have suggestions on which places may or may not have available data.

The sampling should specify which regions or districts will be visited; and within the districts, which sub-districts and health centers. A target number of CHWs for each health center should be determined. In previous experience using this tool, 3-4 CHWs per health center were targeted for interviews, and between 10-15 health centers were selected for the sample. This sample was large enough to provide a 'reality check' of the iCCM program implementation on the ground, but also feasible to cover over a period of approximately three weeks.

Timing the Data Collection Visit

The amount of time needed to collect data depends on the following: 1) sample size; 2) number of staff supporting the activities, including the number of data collectors; 3) geographical context of country and sample selection, including the ease of travel for data collection and the sample size; and 4) availability of those who will need to be interviewed, most especially for government employees and partners.

From the experience gained in previous field visits, data collectors typically spend two days per district sampled: one day at the district health unit, and one day at the health center (during which they are able to interview both the health center staff, as well as the CHWs). The timing of the visits should be planned according to the time necessary for travel, as well as the availability of the person being interviewed. Some additional time should be allotted for any unfortunate events or issues that may arise (such as delays in starting the interviews or logistical problems).

Logistics

The following needs to be arranged prior to starting data collection:

- Adaptation of data collection tools, if required (see section below for more information)
- Finalize and confirm the list of interviewees, including their contact number
- Schedule the interviews (agree on meeting time/location)
- Drivers and vehicles for data collectors
- Data collectors (see section below for more information)
- Binders for data collectors, consisting of:
    - Data collection protocol
    - All necessary data collection tools and relevant materials
    - Paper or note pad, post-it notes, and pens
    - List of interviewees names and contact numbers, with the scheduled meeting times and locations
- Per diems/allowances for drivers and data collectors, if required
- Cameras, used for taking pictures of data only available in hard copy
- Computers, if documenting interviews electronically, along with computer battery charger or spare battery

A number of lessons learned from previous field data collection visits are documented below.

In order to reduce the time needed for data collection, the interviewer should have the CHWs gather at a central location (e.g., health center) to conduct the interviews, rather than travel to each of the CHWs separately. Whenever possible, confirm the interview time and location with the interviewee the day prior. During this time, also mention the types of questions that will be asked and the data that will need to be collected. This will allow the interviewee to gather any necessary documents before the interview. It is beneficial to reconfirm the interview the morning of as well. Schedule all interviews and meetings well in advance, and ensure to keep an accessible list of phone numbers for each interviewee.

Most often, data is only available in a hard copy. In these cases, the data collector should take photographs of the documents. In addition, when photographing the document the data collector should clearly make a note in the photo of what the document is and where it came from. Keeping a pile of post-it notes for this purpose is most useful, and allows one to accurately recall what the information came from during the analysis phase. Be sure to hold cameras steady to avoid blurry photos.

Data collected during the interviews may be collected either via hard copy or on a computer, depending on the preference and availability. If the data collector decides to document the responses in a computer, s/he should ensure to continuously back up the information to ensure no data is lost. External hard drives or USB sticks are valuable to save data in multiple locations to avoid data loss as well. In addition, as interviews can last all day, it is helpful to bring along an extra computer battery charger.

Following the data collection, data collectors should sit down and review questionnaires and responses to ensure that information is clear, and anything that may have been missed during the interview is appropriate captured. Doing this the night after the interviews ensures the information is from that particular day, as opposed to at the end of the data collection when information blends together.

Data Collection Tools

The main data collection tools for the district, health center and community level are questionnaires, applied via oral interviews. A questionnaire has been developed for each level of the health system (See Annex C for detailed questionnaires). After defining the purpose of the tool and completing the preparatory research, the questionnaires should be adapted to most accurately reflect the country and iCCM program context. Where needed, the data collection tools should be translated into the local language(s).

Adapting the questionnaires to suit the local context should be done in two phases: first, a review of the standard questionnaires in Annex C to determine which changes should be made immediately to fit the context. For example, we use the standard terminology "community health worker (CHW)" but this should be changed to reflect whatever is used in the country – such as agent de santé communautaire (ASC), village health worker (VHW), etc. After making these changes to the questionnaires, the second phase should be a pilot test of the instruments in the field with real CHWs. This second phase will ensure that any subtleties relating to the local context are captured. If the questionnaires have been translated to the local language, the pilot test is an opportunity to ensure that the questions are all comprehensible, and will indicate any areas where more clarification is needed. Also, the pilot test will enable to team to assess approximately how long the interview should take per CHW, and plan the field visits accordingly.

Four sample questionnaires are included:

- district level questionnaire (Annex C1): to determine the staff involved in managing or supervising the iCCM program at the district level; enter these staff and salaries in the "Management" and "Supervision" worksheets of the tool.

- health center level questionnaire (Annex C2): to determine the staff involved in managing or supervising the iCCM program at the health center level; enter these staff and salaries in the "Management" and "Supervision" worksheets of the tool.
- CHW questionnaire (Annex C3): to determine the types of activities and treatments provided by CHWs and the average time needed to provide one iCCM services; enter this information in the "Interventions" worksheet of the tool.
- CHW time template (Annex C4): to get a detailed time table of a typical CHW work week; enter this information in the "CHWs" worksheet of the tool.

Selection and Training of Data Collectors

Data collectors should be selected based on the following: ability to appropriately communicate in the local language; and familiarity with interviewing techniques (previous experience helpful). Familiarity with the iCCM and/or community health activities is also a useful trait for the data collectors, as this will aid in their ability to obtain and document responses, as well as understand the context.

After data collectors have been selected, a brief protocol for data collection should be developed (which addresses data collection tools, interview techniques, and procedures). Training on this protocol should be provided to the data collectors prior to implementing data collection activities. During the training, information on the local context and background of the study should be provided. This will ensure consistency across the data collectors, and enable them to more appropriately apply the questionnaires.

Once data collectors have been trained, they should field test the questionnaires (with supervision from the main users of the tool). This will not only ensure that the data collectors are consistent in their techniques, but also ensure the tools are appropriate to the local context.

Data Collection

Conduct the data collection.

4. Data entry and analysis

Partner and central level data should be entered directly into the iCCM Costing and Financing Tool, if possible. District, health center and community level questionnaire data should be cleaned and entered into an electronic database such as Microsoft Excel. Detailed instructions for data entry into the tool are available in Section II of this document.

Section II: Tool User Guide

This section provides has detailed step-by-step instructions on how to enter data into the iCCM Costing and Financing Tool. Two versions of the tool are available: a blank version and a demo version with sample data filled in. The examples in this section of the user guide have been generated using the demo version of the tool. Once all the requisite information has been collected, use the blank version of the tool to start entering data.

1. Overview of the iCCM Costing and Financing Tool

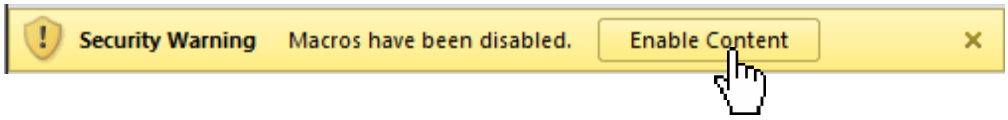
The iCCM Costing and Financing Tool is divided into five sections, as described in Figure 2. below. Each section has a corresponding tab color in the tool.

Figure 2. Description of sections and worksheets in the iCCM Costing and Financing Tool

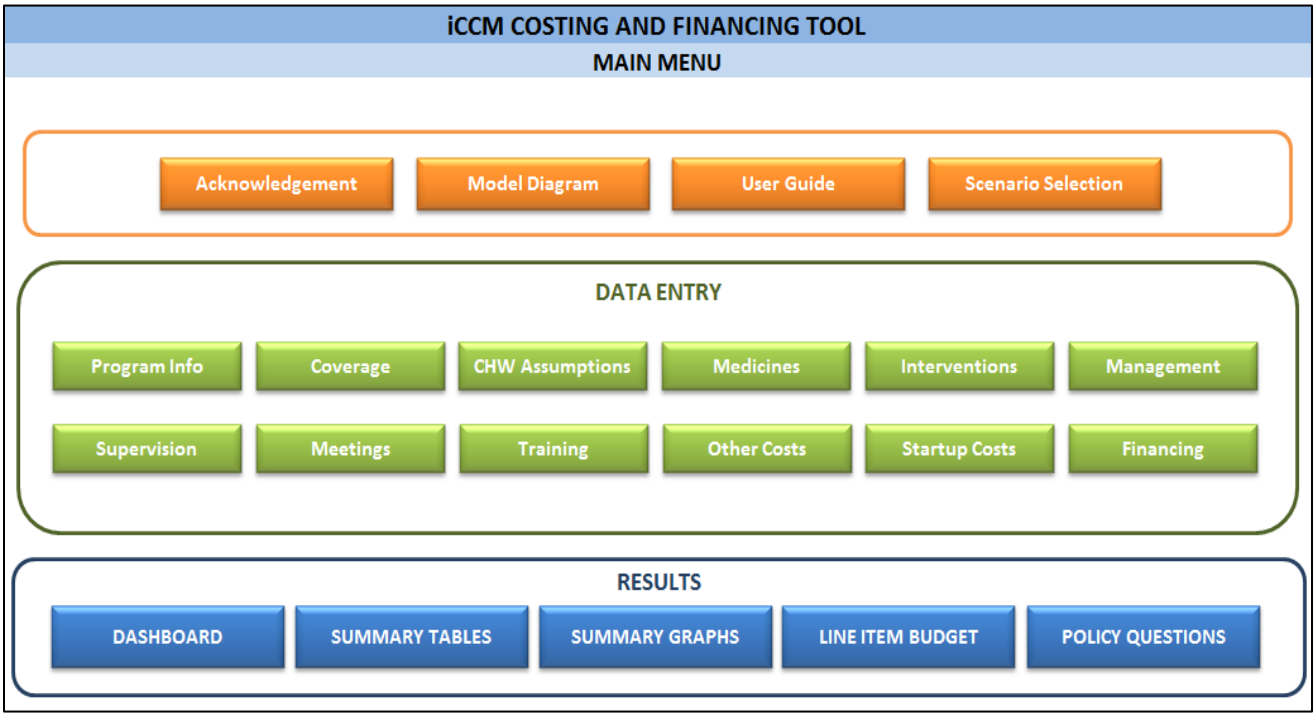
Section	Tab Color	Description	Worksheets Included	Worksheet Description
1	Orange	Background		
			Acknowledgement	Acknowledgements for iCCM Costing and Financing Tool
			Main Menu	Main Menu for quick navigation around the tool
			Diagram	Diagram of inputs, intermediate calculations, and outputs of the tool
			User Guide	This page; refer to iCCM Costing and Financing Tool User Manual for detailed guide
			Scenarios	Scenario selection to determine how the tool will be used
2	Green	Data Entry		
			Program Info	Input the country and iCCM Program general information
			Coverage	Input baseline and target coverage for program and incidence rates for iCCM services
			CHWs	Input information about CHW time availability and salary, if applicable
			Equipment & Medicines	Input the standard equipment and essential medicines provided to CHWs
			Interventions	Input the standard treatment guidelines for each intervention in iCCM package
			Management	Input the management costs for iCCM Program in terms of staff and salary costs
			Supervision	Input the supervision costs for iCCM Program in terms of staff and salary costs
			Meetings	Input the cost of meetings and supervision visits for iCCM Program
			Training	Input the cost of startup and refresher trainings and TOTs for iCCM Program
			Other Costs	Input any other recurrent iCCM Program costs
			Startup	Input the costs of any startup activities (not including CHW startup training)
			Financing	Input the anticipated funding by source for the iCCM Program
3	Blue	Results		
			Dashboard	Key results presented in dashboard format; selection of currency to display (USD or local)
			Summary Tables	Summary of key results presented in table format
			Summary Graphs	Summary of key results presented in graph format
			Line Item Budget	Line item budget for iCCM Program
			Policy Questions	Key policy questions asked and where to find the answers in results pages
4	Red	Calculations		
			Calculations - Services	Calculates the number of iCCM services provided by year for each scenario
			Calculations - Total Cost	Calculates the total iCCM program cost and the cost by component
			Calculations - Cost per Servi	Calculates the cost per service for each intervention in the iCCM package
			Calculations - Financing	Calculates the funding available and funding gaps for the iCCM Program
5	No color	Annexes		
			Annex A. Caseloads	Blank sheet to copy and paste raw data on iCCM cases treated
			Annex B. CHW Questionnair	Sample questionnaires used to collect actual data from CHWs and their supervisors
			Annex B1. District	District level questionnaire
			Annex B2. Health Center	Health Center level questionnaire
			Annex B3. CHW	CHW questionnaire
			Annex B4. Supervision	Template for staff involved in iCCM supervision and salary information
			Annex B5. Training Meeting	Template for trainings and meetings for CHWs
			Annex B6. CHW Time	Template for CHW time recall questions

2. Tool Navigation

When opening the iCCM Costing and Financing Tool, ensure that macros are enabled so that the tool functions correctly. To enable macros, go to the Excel menu and select the following: File -- Options -- Trust Center -- Trust center settings -- Macro Settings -- Enable all macros. Or, select "Enable content" at the prompt:

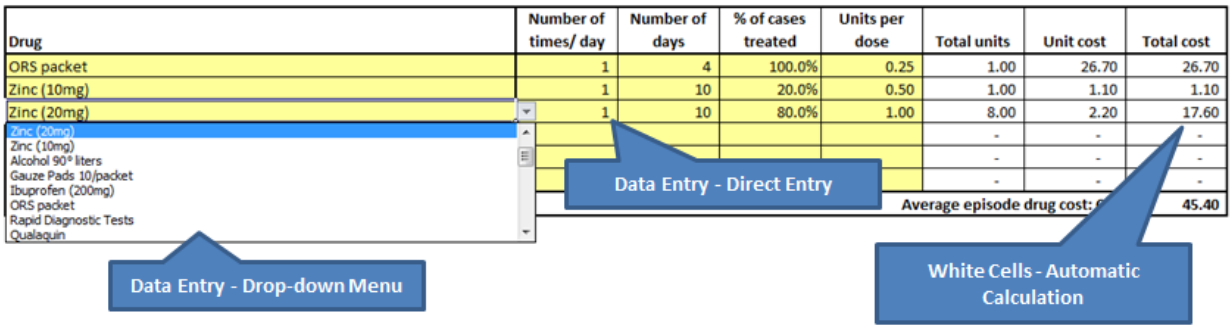


The iCCM Costing and Financing Tool should automatically open at the Acknowledgements page. Use the blue "Main Menu" button to navigate to the Main Menu. This worksheet will allow for quick navigation to the main sections of the tool that should be used: the background worksheets, the data entry worksheets, and the results worksheets.



In any of the other worksheets, use the tabs along the bottom to navigate to different parts of the tool. Or, use the "Quick Links" navigation buttons at the top of each page:

All data entry should be made in **yellow shaded cells only** (see diagram below). Data entry can occur as a direct entry by the user, or can be made by a selection from a drop-down menu. When cells have a drop-down menu option, all data must be selected using the drop-down menu. Overwriting cells with a drop-down menu may cause errors in the tool calculations. Automatic calculations may appear in white cells. Never delete or overwrite any of the formulas in white cells.



The next sections describe each worksheet in the iCCM Costing and Financing Tool in detail. Use the demo version of the tool when following the examples in this tool user guide. Use the blank version of the tool when you are ready to begin entering data for your program.

Important Tips for using the iCCM Costing and Financing Tool

- **All worksheets in the iCCM tool can be unprotected using the password "iCCM2013".**
- **Never delete any rows, columns, or tables in the tool. Also, never add any rows or columns into the tool. This will disrupt the calculations and the tool will not function correctly.**
- **Cells containing "More Information" and a red triangle in the corner have additional information on how to enter data into the tool. Hover the mouse cursor over these cells to display the comments.**
- **It is recommended to start the data entry with the "Scenarios" page, then enter data in sequential order from worksheet to worksheet, moving from the left to right tabs in the tool.**
- **A number of data entry cells will change color depending on the selections that have been made previously. Yellow shaded cells may switch to grey shaded cells based on the selections made on the "Scenarios" page. Data should be entered in yellow shaded cells; any data entered in grey shaded cells will not be used.**
- **This document uses the generic terms "Community Health Worker", "CHW", and "Village". These terms can be customized in the tool to reflect the country and program-specific context.**

3. Background Worksheets

Acknowledgement

This worksheet is the first page of the iCCM Costing and Financing Tool and includes the acknowledgement information for the tool: The Integrated Community Case Management (iCCM) Costing and Financing Tool was developed by Management Sciences for Health (MSH), under Subagreement No. FY11-G03-6990 funded by Translating Research into Action (TRAction). The TRAction project is funded by the United States Agency for International Development (USAID) under cooperative agreement number GHS-A-00-09-00015-00. The project team includes prime recipient, University Research Co., LLC (URC), and sub-recipient research organizations, including MSH.

Main Menu

The Main Menu is the main navigation page for the tool. Use this page to quickly navigate through the background worksheets, data entry worksheets, and results worksheets.

Diagram

The Diagram provides an overview of the tool, demonstrating which inputs are entered by the user, which are then used to make intermediate calculations, and finally arrive at the final cost calculations in the tool.

User Guide

The User Guide provides brief instructions on using and navigating the iCCM Costing and Financing Tool.

Scenarios

A selection must be made for each of the five questions on the Scenarios worksheet. Fill this section out first as it will have an impact the data that will be entered in subsequent worksheets. Note that the selections in the Scenarios page can be changed at a later stage, but this may require additional information to be filled into the tool. Remember that the iCCM Costing and Financing tool covers a **six-year period**: one baseline year and five projection years.

Question 1: What is the goal: to introduce a new iCCM Program, or to scale up an existing iCCM Program?

- Select ***Scale-Up of Existing iCCM Program*** if the country has an existing iCCM program, to calculate costs and financing requirements for scale-up of the current iCCM program. You will be able to input baseline data on number of iCCM services provided. You can select any of the coverage options in questions 2 and 3 below.
- Select ***Introduction of New iCCM Program*** if the country has no iCCM program, to calculate costs and financing requirements for introduction of a new iCCM program. You will need to select either the target or full-scale coverage options in questions 2 and 3 below.

Question 2: Specify the geographic coverage of the iCCM Program that will be used in this analysis?

Geographic Coverage refers to the geographic areas in the country which are covered by the iCCM Program.

- Select ***Baseline + Target Geographic Coverage*** to input the current actual coverage of an existing iCCM Program for the baseline year. The remaining five projection years will require target coverage figures to be entered. Note: if Baseline + Target Geographic Coverage is selected for question 2, Baseline + Target Service Delivery Coverage should be selected for question 3.
- Select ***Target Geographic Coverage*** to input the target number of provinces, regions, districts, health centers, and villages that will be covered by the iCCM Program over a six-year period. The user can scale up the geographic coverage gradually by program year, if desired.
- Select ***Full-Scale Geographic Coverage*** to input the Full-Scale (i.e. National) coverage of the iCCM Program. This selection assumes that full-scale coverage will begin with the baseline year and continue for the five projection years. The user will input the assumptions for full-scale geographic coverage on the "Program Info" worksheet.

Question 3: Specify the service delivery coverage of the iCCM Program that will be used in this analysis?

Service Delivery Coverage refers to the coverage of children under five by the iCCM program, within the geographic areas that have been identified under question 2.

- Select ***Baseline + Target Service Delivery Coverage*** to input the actual number of iCCM treatments provided for baseline year. The remaining five projection years will require target coverage figures to be entered, as a % of children covered within the geographic areas that have been entered.
- Select ***Target Service Delivery Coverage*** to input a target number (as % of full met need) of iCCM treatments provided to children in iCCM-covered geographic areas.
- Select ***Full-Scale Service Delivery Coverage*** to input the number of iCCM treatments provided to fully meet the need of children in iCCM-covered areas. This selection assumes that 100% of children under 5 will be treated through iCCM in the geographic areas covered by the program.

Question 4: At what level will this analysis be conducted?

- Select the level of analysis for the iCCM Costing and Financing Tool: ***National, Province, District***, or ***Other***. If ***Other*** is selected, input the desired level in the adjacent yellow shaded cells.

Question 5: Select a method of calculating the number of Community Health Workers required?

- Select ***Manual Input*** to enable the user to enter the number of CHWs per program year manually. If this scenario option is selected, you must also enter the number of CHW supervisors manually.

- Select ***CHW per Population Ratio*** to calculate the number of CHWs required for the scenario based on the desired ratio of CHWs per 1,000 Population. This assumption will be input by the user on the "CHWs" worksheet.
- Select ***CHW per Village*** to calculate the number of CHWs required for the scenario based on the number of villages covered by the iCCM Program, and number of CHWs per village. This assumption will be input by the user on the "CHWs" worksheet.
- Select ***Disease Burden and CHW Availability*** to calculate the number of CHWs required for the scenario based on the disease burden (number of episodes per child per disease area x population <5 covered), the time required to provide the treatments, and the CHW time available.

4. Data Entry Worksheets

Program Information

1. National / Sub-National Information

Input the country name, currency, exchange rate, annual inflation rate, and annual salary increase rate. In the demo version below, questions 1.2 and 1.8 are greyed out since the "National" level scenario was selected for Question 4 in the "Scenarios" worksheet. The annual inflation rate and annual salary increases will be applied to all costs and salaries for each projection year in the tool. Note: all costs entered into the tool should be in the same currency that has been indicated below. Automatic conversion to USD is available in the results worksheets.

1.1	What is the Country Name?		Demo Version
1.2	What is the National Name?		
1.3	What is the national currency?		CFA
1.4	What is the exchange rate to USD?	*1 USD =*	499
1.5	What is the average annual inflation rate (%)?		2.5%
1.6	What is the average annual salary increase (%)?		3.0%

Input the total national population, and, if a sub-national selection was indicated in Question 4 on the "Scenarios" worksheet, input the population of that sub-national level in question 1.8. Input the proportion of the population living in remote or hard to reach areas in question 1.9. This percentage will be applied to the total population to determine the population to be covered by the iCCM program.

1.7	What is the total National population (baseline year)?	18,258,000
1.8	What is the total National population (baseline year)?	
1.9	What proportion of the population is living in remote / hard to reach areas that will be covered by the iCCM Program (%)?	68%
1.10	What is the annual population growth rate (%)?	2.5%
1.11	What is the proportion of newborns (0-28 days old) as a % of total population?	3.0%
1.12	What is the proportion of infants (0-12 months old) as a % of total population?	4.5%
1.13	What is the proportion of children (2-59 months old) as a % of total population?	14.0%
1.14	What is the proportion of children (0-59 months old) as a % of total population?	17.2%
1.15	What is the proportion of pregnant women (as a % of total population)?	8.0%

1.15	What is the date of this analysis?	10/22/2013

Input the annual population growth as a percentage in question 1.10; this figure will automatically be applied to the total population for each projection year in the tool. Input the proportion of newborns, infants, children, and pregnant women in 1.11 – 1.15; these percentages will be used to calculate the target population for each iCCM service.

2. Country Administrative Structures

Input the Country Administrative Structures, beginning with the first and highest level (National or Central) and working down. The last level should be reserved for the geographical area covered by the CHW (such as a Village, Community, or Hard-to-Reach Area).

		Name	Total Number of Structures
2.1	First Level	National	1
2.2	Second Level	Province	4
2.3	Third Level	Region	16
2.4	Fourth Level	District	200
2.5	Fifth Level	Health Center	1,240
2.6	Community Level	Village	18,000

2.7	What is the average population size per Village?	850

The number of administrative structures input here will be used as the basis for the "Full Geographic Coverage" option selected under Question 2 on the "Scenarios" worksheet.

3. Program Assumptions

Input the desired Baseline Program Year and the Final Program Year. The tool can accommodate a total of six years – the baseline year and five projection years.

3.1	What is the Baseline Program Year (start of calendar year)?	2013
3.2	What is the Final Program Year (end of calendar year)?	2018
	Length of Program	6

3.3	How many different types of CHWs providing iCCM services?	1

		Full Title	Abbreviation
3.4	Title of Community Health Worker 1	Community Health Volunteer	CHV
3.5	Title of Community Health Worker 2		

3.6	Title of CHV Supervisor	Peer Supervisor

The tool allows up to two different types of CHWs to be input; if there is more than one cadre of community health worker that provides iCCM, select "2" from the drop-down menu in question 3.3. If there is only one type of CHW that provides iCCM, then leave the selection as "1". Enter the full title of the CHW and the abbreviation. This abbreviation will be used throughout the tool.

Enter the title of the direct CHW supervisor in question 3.6; this can be the In-Charge at a health center or a full-time supervisor hired by an implementing NGO.

4. Interventions in iCCM Package

The user can input up to ten different services in the iCCM package. Typically, iCCM services comprise pneumonia, diarrhea and malaria treatment; however, the tool has the flexibility to include any other services that are currently being offered, or will be offered in the future. Select the appropriate target population for each service from the drop-down list. These target populations will be used to calculate the number of expected cases for each service. For example, the newborn sepsis treatment service below should target newborns specifically.

	Service	Target Population
Service 1	Pneumonia treatment	Children (2-59 months)
Service 2	Diarrhea treatment	Children (2-59 months)
Service 3	RDT for fever cases	Children (2-59 months)
Service 4	Treatment of confirmed malaria	Children (2-59 months)
Service 5	Neonatal sepsis treatment	Newborns (0-2 months)
Service 6		
Service 7		
Service 8		
Service 9		
Service 10		

The above example separates RDT for fever cases and treatment of confirmed malaria into two distinct services. The user will be required to input an incidence rate for each service, and this rate will be different for fever cases and true malaria cases. For countries where malaria is treated presumptively (i.e., no RDT used for diagnosis), a single malaria service will be sufficient, but the incidence rate used should be for all fever cases.

5. Sources of Financing for iCCM Program

As the name suggests, the iCCM Costing and Financing tool includes a financing component, which allows the user to input confirmed or expected sources of funding for the iCCM program. These sources will later be used on the "Financing" worksheet. Up to ten different sources may be input; these can be general (i.e., "Donor funding") or specific (i.e., "Global Fund"), depending on the information available.

Source 1	National government
Source 2	UNICEF
Source 3	Global Fund
Source 4	NGO
Source 5	Other donor
Source 6	
Source 7	
Source 8	
Source 9	
Source 10	

Coverage

The iCCM Costing and Financing Tool requires the user to enter two types of coverage figures: geographic coverage and service delivery coverage. Depending on the selections that have been made for questions 2 and 3 on the "Scenarios" worksheet, the "Coverage" worksheet will have different cells highlighted for data entry.

1. Geographic Coverage Assumptions

First, input the geographic coverage. All geographic coverage assumptions depend on the scenario selection made for question 2 on the "Scenarios" worksheet. The questions in 1.1-1.10 will be filled out based on the information that has been entered on the "Program Info" worksheet.

If "Full-Scale Geographic Coverage" was selected on the "Scenarios" worksheet, no data entry is required. The Full Coverage assumptions will be shown in white in column C.

In the example below, "Target + Baseline Geographic Coverage" was selected in question 2 of the "Scenarios" worksheet. As a result, the columns for baseline and Y1-Y5 are highlighted in yellow for data entry. If "Target Geographic Coverage" is selected, the columns for Y0-Y5 will be highlighted for data entry. Input the geographic coverage assumptions in the yellow shaded columns as indicated.

1) Geographic Coverage Assumptions — More Information

Selected Scenario: *Baseline + Target Geographic Coverage*

				TARGET GEOGRAPHIC COVERAGE					
				Y0	Y1	Y2	Y3	Y4	Y5
		FULL COVERAGE	BASELINE	2013	2014	2015	2016	2017	2018
1.1	Number of National level with iCCM coverage	1	1	1	1	1	1	1	1
1.2	Number of Provinces with iCCM coverage	4	3	3	3	3	4	4	4
1.3	Number of Regions with iCCM coverage	16	12	12	13	14	15	16	16
1.4	Number of Districts with iCCM coverage	200	150	150	160	170	180	190	200
1.5	Number of Health Centers with iCCM coverage	1,240	940	940	1,020	1,100	1,160	1,200	1,240
1.6	Number of Villages providing iCCM	18,000	12,800	12,800	13,840	14,880	15,920	16,960	18,000
1.7	Total target population covered by iCCM Program (all ages)	12,415,440	9,425,000	9,425,000	10,250,000	11,325,800	12,852,000	13,450,000	14,398,000
1.8	Total Number of CHVs (Manual Input)		6,400	9,400	8,320	10,240	12,160	14,080	16,000
1.9	Total Number of CHW2s (Manual Input)								
1.10	Total Number of Peer Supervisors (Manual Input)		55	90	90	100	120	140	160

Input the total number of CHWs and CHW Supervisors in 1.8-1.10 if "Manual Input" has been selected for question 5 in the "Scenarios" worksheet. If any of the other CHW calculation options have been selected, 1.8-1.10 should be left blank.

2. Service Delivery Coverage Assumptions

Next, input the service delivery coverage. Once again, the service delivery assumptions depend on the scenario selected in question 3 on the "Scenarios" worksheet.

If "Full-Scale Service Delivery Coverage" was selected on the "Scenarios" worksheet, no data entry is required. The Full Coverage assumptions will be shown in white in column C, indicating that 100% of all children within the geographic coverage areas will be treated through iCCM.

In the example below, "Target + Baseline Service Delivery Coverage" was selected in question 3 of the "Scenarios" worksheet. As a result, the columns for baseline and Y1-Y5 are highlighted in yellow for data entry. Note that the gradual introduction of a service can be indicated in this section, as demonstrated with neonatal sepsis treatment in the example above, which assumes that the treatments will be rolled out in 2015. In the previous years, there is 0% coverage.

2) Service Delivery Assumptions — More Information

Selected Scenario: *Baseline + Target Service Delivery Coverage*

				TARGET SERVICE DELIVERY COVERAGE					
				Y0	Y1	Y2	Y3	Y4	Y5
		FULL COVERAGE	BASELINE - CASES TREATED	2013	2014	2015	2016	2017	2018
2.1	Pneumonia treatment	100%	105,850	31%	36%	41%	46%	50%	50%
2.2	Diarrhea treatment	100%	652,000	15%	20%	26%	32%	38%	50%
2.3	RDT for fever cases	100%	1,350,000	32%	37%	42%	47%	50%	50%
2.4	Treatment of confirmed malaria	100%	375,000	30%	35%	40%	45%	50%	50%
2.5	Neonatal sepsis treatment	100%	-	0%	0%	10%	15%	20%	25%
2.6									
2.7									
2.8									
2.9									
2.10									

If "Target Geographic Coverage" is selected, the columns for Y0-Y5 will be highlighted for data entry. Input the service delivery coverage assumptions in the yellow shaded columns as indicated. For the baseline, input the actual number of cases treated. For Y0-Y5, input the target as a % of children that will be treated by iCCM. In the example above, in 2014, we assume 20% of the expected child diarrhea cases will be treated by iCCM.

3. Epidemiology Assumptions

Finally, input the incidence rate for each service in the iCCM package. The incidence rate is defined as the number of episodes per child per year. The incidence rate should correlate to the target population selected for each service. The rate can be maintained across the program years or changed from year to year.

3) Epidemiology Assumptions *More Information*

			Incidence Rate (Number of Episodes per Child per Year)					
			Y0	Y1	Y2	Y3	Y4	Y5
		Target Population	2013	2014	2015	2016	2017	2018
3.1	Pneumonia treatment	Children (2-59 months)	0.26	0.26	0.26	0.26	0.26	0.26
3.2	Diarrhea treatment	Children (2-59 months)	3.30	3.30	3.30	3.30	3.30	3.30
3.3	RDT for fever cases	Children (2-59 months)	3.15	3.15	3.15	3.15	3.15	3.15
3.4	Treatment of confirmed malaria	Children (2-59 months)	0.95	0.95	0.95	0.95	0.95	0.95
3.5	Neonatal sepsis treatment	Newborns (0-2 months)	0.20	0.20	0.20	0.20	0.20	0.20
3.6								
3.7								
3.8								
3.9								
3.10								

CHWs

The CHWs worksheet is used to input assumptions on the availability and ratio of CHWs to population and villages. If you have selected 2 types of CHWs on the "Program Info" worksheet, both columns will be highlighted in yellow for data entry. Otherwise, if there is only one type of CHW, a single column will be highlighted in yellow for data entry, as shown below.

1. CHW Ratios and Availability

Input the desired ratio of CHWs per 1,000 population (i.e., if the desired ratio is 1 CHW per 500 population, input 2 per 1,000). This information must be entered if you have selected the "CHW per Population Ratio" scenario for question 5 on the "Scenarios" worksheet.

Input the ratio of CHWs per village or community. This information must be entered if you have selected the "CHW per Village" scenario for question 5 on the "Scenarios" worksheet.

Input the desired ratio of CHWs to their direct supervisors. In the example below, a supervisor would oversee 15 CHWs.

Input the annual CHW attrition rate as a percentage of the total number of CHWs. This figure will be used to calculate the additional number of CHWs that need to be trained to replace those lost to attrition.

	1) CHV Ratios and Availability		More Information
		CHV	-
1.1	What is the desired ratio of CHVs per 1,000 Target Population?	2	
1.2	What is the desired ratio of CHVs per Village?	1	
1.3	What is the desired ratio of CHVs per Supervisor? (i.e. X number of CHVs per one supervisor)	15	
1.4	What is the CHV yearly Attrition Rate (%)?	5%	
1.5	How many hours / week are available per person to work as a CHV?	25	
1.6	How many weeks / year are available per person to work as a CHV?	52	
1.7	How many hours / week are available per CHV to provide iCCM services?	20	
	Total hours / year available to work as CHV	1,300	-
	Total hours / year available for iCCM	1,040	-
	% of overall CHV time attributed to iCCM	80%	0%
	iCCM Percent Attribution	80%	

Input the hours per week and weeks per year available per person to work as a CHW, as well as the time that can be spent specifically providing iCCM services. This information can be based on standards from a CHW policy; however, since most CHW programs involve volunteer workers with no standard working hours, it may be necessary to base this information from the CHW questionnaires (see Annex C).

The proportion of a CHW's time that is spent on iCCM activities, as opposed to other CHW activities, is labeled "iCCM Percent Attribution" in the tool. This percentage will be applied to any costs entered into the tool that would be shared by the overall CHW program (in the tool, this will be indicated by the question: "iCCM-specific or General cost"?). For example, if a bicycle is provided to the CHW for a number of different activities – provide iCCM treatments, conduct promotional talks in the villge, travel to the health center for general CHW meetings – the cost of the bicycle should not be attributed 100% towards the iCCM program, but rather shared across the entire CHW program. In the example above, since 80% of the CHW's activities relate to iCCM, we would allocate 80% of the cost of a bicycle towards the iCCM program, and assume that the remaining 20% will be covered by a separate program.

2. CHW Salary

Indicate whether the CHW receives any form of payment or incentive by selecting "Yes" or "No" from the drop-down menu in 2.1. If "Yes" has been selected, 2.2 will be highlighted in yellow to indicate that data should be entered; enter the annual payment or incentive per CHW in the indicated currency. This salary will be applied to all CHWs and will automatically be increased annually based on the salary increase rate entered on the "Program Info" worksheet.

	2) CHV Salary: (CFA)		More Information
		CHV	-
2.1	Does the CHV receive any form of payment or incentive?	No	
2.2	If Yes, what is the total annual payment or incentive per CHV (in CFA)?		

Medicines & Equipment

Enter all medicines, supplies, and equipment provided to CHWs and their supervisors on this worksheet. This information be entered according to standard protocols, and should disregard any stock-outs. In order to fully understand the "Medicines & Equipment" worksheet, it is also important to understand the "Interventions" worksheet which is the following tab in the iCCM tool Excel file.

1. CHW Medicines and Supplies

First, list the standard medicines and supplies that are provided to CHWs. These should all be medicines and supplies that are used for iCCM treatments, and should not include equipment that is used multiple times (for example, a needle safety box should not be included). Input the unit description and unit cost for each medicine, making sure to correlate the two together. For example, if the unit of ACT is per blister, ensure that the unit cost for ACT is per blister as well.

Enter each medicine individually. If there is a treatment regimen with multiple types of medications provided, each separate medicine should be input into a separate row. Where there are different dosages of the same medicine, enter the medicine twice and indicate the dosage in the title, as shown in the example with cotrimoxazole below.

1) CHV Medicines and Supplies

What is the % mark-up on medicines for transport, storage, management, and distribution?	10%

	Name of Medicine or Supply	Description (per pill, per treatment, etc.)	Unit Cost (CFA)
1	ACT: Artemether + Lumefantrine (20 mg + 120 mg) 6x1 blister pack	per blister	261
2	ACT: Artemether + Lumefantrine (20 mg + 120 mg) 6x2 blister pack	per blister	525
3	Rapid Diagnostic Test (RDT)	per test	500
4	Oral rehydration salts (ORS), powder sachet for 1000ml	per sachet	32
5	Zinc (10mg)	per tablet	17
6	Cotrimoxazole (120 mg)	per tablet	2.2
7	Cotrimoxazole (240 mg)	per tablet	2.5
8	Amoxicillin (125 mg/ 5 ml)	per ml	2.4

The iCCM Costing and Financing Tool has an option to enter the mark-up on medicines for transport, storage, management, and distribution. This should be entered as a percentage and will be applied to each unit cost (for example, a 10% mark-up would increase the unit cost of Zinc in the example above from 17 CFA per tablet to 18 CFA. The 18 CFA unit cost would be applied to the total units of Zinc dispensed for iCCM treatments to arrive at the total cost of Zinc). If the percentage for mark-up is already included in the unit cost of the medicines, or if it is unknown, leave this cell blank.

2. CHW Equipment

Enter the equipment provided to CHWs in the second section. Equipment can be defined as any materials provided to the CHWs that are used multiple times in the course of their work. This can include materials related to providing treatments such as: medicine boxes, ARI timers, and MUAC tape. This can also include other materials provided to CHWs as incentives or motivations such as bicycles, t-shirts, or boots. For each piece of equipment, indicate whether it is specifically relating to the iCCM program, or whether it is a general CHW program cost (see the note on the previous page about sharing program costs). In the example below, the ARI timer and the iCCM register were provided specifically to provide iCCM treatments, but the remaining equipment was provided for all activities conducted by the CHW. Thus, for each of the "general" equipment, a portion of the unit cost will be allocated towards the iCCM program.

Indicate the replacement frequency of each item in years using the drop-down menu. Selecting "0" indicates that the CHW is given the item a single time and the equipment should last throughout the duration of the project (or, for the purposes of the tool, throughout the 6-year period). Selecting "1" indicates that the piece of equipment is replaced yearly, and so on. If the

equipment is replaced twice a year, simply double the unit cost to indicate that two units are given at a time, and select "1" for the replacement frequency.

2a) CHV Equipment				More Information
What is the % mark-up on equipment for transport, storage, management, and distribution?			10%	
	Item	Equipment for iCCM Only or General Use?	Unit Cost (CFA)	Replacement Frequency (Years)
1	Medicine box	General	12,000	0
2	MUAC	General	500	1
3	Timer	iCCM	510	1
4	Boots	General	600	1
5	Jerrycan	General	250	1
6	Goblet	General	300	1
7	Spoon	General	150	1
8	Rain coat	General	8,000	0
9	Torch	General	2,500	1
10	Backpack	General	5,200	0
11	Plastic bags	General	510	1
12	Safety Boxes	General	1,800	0
13	Umbrella	General	3,000	2
14	iCCM Register	iCCM	3,200	1
15	Patient Register	General	4,200	1
16				
17				
18				
19				
20				

3. CHW Supervisor Equipment

Input any equipment provided to the CHW's direct supervisor (as indicated on the "Program Info" worksheet), using the same instructions as for the CHW Equipment in section 2 above.

Interventions

Input the standard treatment guidelines for each service in the iCCM package on the "Interventions" worksheet. The names of the services will automatically be filled in based on the data entered on the "Program Info" worksheet.

First, input the "Time Required for One Full Treatment Including Follow-Up" in minutes for each of the iCCM interventions provided by the CHW. This time includes the initial visit (diagnosis and initial treatment) as well as the time it takes for a follow-up, if applicable.

Next, select each medicine or supply that is required for one treatment using the drop-down menu in column B. **Note: never input a drug name directly into column B of the "Interventions" worksheet; always use the drop-down menu. Any changes to the medicine name should be made on the "Medicines & Equipment" worksheet.** Once the selection has been made, the unit cost should automatically populate in column H.

Input the number of times per day each medicine is given to the child, the total number of days for the regimen, and the units per dose. This should be inclusive of medicines provided to the parent or guardian to give to the child after the initial visit by the CHW. **Note: ensure that the units per dose are in accordance with the unit cost entered in the "Medicines & Equipment" worksheet.** In the example of malaria below, the unit cost was entered per blister, therefore the unit per dose is 1/6 = 0.17 for the first treatment (6-pill blister) and 1/12 = 0.08 for the second treatment (12-pill blister).

4) Treatment of confirmed malaria	More Information

Time required for one full treatment including follow-up (mins):	30

Name of Medicine or Supply	Number of times/ day	Number of days	% of cases treated	Units per dose	Total units	Unit cost	Total cost
ACT: Artemether + Lumefantrine (20 mg + 120 mg) 6x1 blister pack	2	3	12.4%	0.17	0.12	287.10	35.60
ACT: Artemether + Lumefantrine (20 mg + 120 mg) 6x2 blister pack	4	3	87.7%	0.08	0.88	577.50	506.47
					-	-	-
					-	-	-
					-	-	-
					-	-	-
					-	-	-
					-	-	-
					Average episode medicines cost: CFA		542.07

Input the % of cases treated – this is for medicines that are given to only a subset of cases, or can be used to indicate different dosages based on weight or age. In the example above, for malaria, a 6x1 ACT blister is given for children under 1, and a 6x2 blister of ACT for children between 1 and 5 years. The % entered indicates the proportion of children under five who are under 1 year of age (12.4%), and the proportion that are between 1 and 5 years (87.7%).

Once all the information has been entered correctly, the "Total units" and "Total cost" columns should automatically populate. Repeat the data entry for all the remaining services in the iCCM package.

Management

All salary costs for staff involved in the management of the iCCM program should be entered in the "Management" worksheet.

First, make a list of all staff involved in managing the iCCM program in the geographic coverage areas that have been indicated on the "Coverage" worksheet. This can include MOH staff and implementing partner staff. Administrative and support staff such as drivers can also be included.

1) Enter all staff involved in iCCM Program Management	More Information

					% OF SALARY ATTRIBUTED TO iCCM PROGRAM MANAGEMENT					
	Administrative Level	Name / Title	Organization	Annual Salary: (CFA)	2013	2014	2015	2016	2017	2018
1	National	National Director	NGO	30,000,000	11%	11%	11%	11%	11%	11%
2	National	Finance Director	NGO	25,000,000	11%	11%	11%	11%	11%	11%
3	National	CCM Advisor 1	NGO	15,000,000	100%	100%	100%	100%	100%	100%
4	National	CCM Advisor 2	NGO	15,000,000	100%	100%	100%	100%	100%	100%
5	National	FP/RH Advisor	NGO	15,000,000	25%	25%	25%	25%	25%	25%
6	National	M&E Advisor	NGO	10,000,000	50%	50%	50%	50%	50%	50%
7	National	M&E Assistant	NGO	10,000,000	50%	50%	50%	50%	50%	50%
8	National	BCC Advisor	NGO	10,000,000	50%	50%	50%	50%	50%	50%
9	National	Administrative Assistant	NGO	5,000,000	33%	33%	33%	33%	33%	33%
10	National	Driver	NGO	5,000,000	33%	33%	33%	33%	33%	33%
11	National	Office Support Staff	NGO	1,000,000	33%	33%	33%	33%	33%	33%
12	National	Head of Community Health	MOH	15,000,000	40%	40%	40%	40%	40%	40%
13	National	Head of Maternal, Newborn	MOH	15,000,000	25%	25%	25%	25%	25%	25%
14	National	M&E Officer	MOH	10,000,000	10%	10%	10%	10%	10%	10%
15	National	Administrative Officer	MOH	5,000,000	15%	15%	15%	15%	15%	15%
16	National	Community Health Support	MOH	1,000,000	45%	45%	45%	45%	45%	45%

For each staff involved in management, indicate the administrative level where they are based using the drop-down menu in column B. Input the name and title of the staff, the organization, and the annual salary in columns C-E. The annual salary will automatically be increased for the projection years based on the assumptions input on the "Program Info" worksheet.

Input the percentage of time spent by each staff on management of the iCCM program, for each program year. This figure will be multiplied by the annual salary to determine the amount allocated towards the iCCM program. The percentages can be maintained across the five projection years, or increased or decreased based on planned changes in the program.

Supervision

All salary costs for staff involved in the supervision of the iCCM program should be entered in the "Supervision" worksheet.

First, enter the administrative level and annual salary for the CHW's direct supervisor. Enter the percentage of the supervisor's time spent on the iCCM program. If the CHW supervisor's only role is to provide supervision, such as in the example below, enter 100% for the percentage of salary attributed to supervision.

Based on the selection made for question 5 on the "Scenarios" page, "Method of CHW calculation", the number of CHW Supervisors will either be automatically calculated by the tool (based on the ratio of CHWs to supervisors entered on the "CHWs" worksheet) or should be manually entered into the tool on the "Coverage" worksheet.

Next, make a list of all additional staff involved in supervising the iCCM program in the geographic coverage areas that have been indicated on the "Coverage" worksheet. Indicate the administrative level where the supervisors work, their title, and the number of staff per administrative level. Then enter the annual salary per staff.

The tool will automatically determine the number of staff required, based on the assumptions in the "Coverage worksheet". In the example below, there is 1 District Medical Officer per District; since there are 150 districts covered by the program in the baseline year, there would be a total of 150 District Medical Officers. Therefore, the 1,000,000 CFA salary will be multiplied by 150 District Medical Officers, and then again by the 5% of the salary that is attributed to the iCCM program.

1) Enter all staff involved in supervision of CHVs providing iCCM | *More Information*

	Administrative Level	Title	# Staff per Administrative Level	Annual Salary per Staff: (CFA)	% OF SALARY ATTRIBUTED TO iCCM SUPERVISION					
					2013	2014	2015	2016	2017	2018
	CHV Direct Supervisors									
1	Health Center	Peer Supervisor	-	500,000	100%	100%	100%	100%	100%	100%
	All other supervisors									
2	Region	Regional Coordinator	1	1,100,000	5%	5%	5%	5%	5%	5%
3	Region	Program Officer	1	950,000	15%	15%	15%	15%	15%	15%
4	District	District Medical Officer	1	1,000,000	5%	5%	5%	5%	5%	5%
5	District	District Supervisor	1	450,000	25%	25%	25%	25%	25%	25%
6	Health Center	Community Development A	1	300,000	50%	50%	50%	50%	50%	50%
7	Health Center	Community Mobilizer	1	200,000	50%	50%	50%	50%	50%	50%
8	Health Center	Health Center in-charge	1	500,000	10%	10%	10%	10%	10%	10%

Meetings

The "Meetings" worksheet allows the user to input all costs associated with iCCM-related meetings for CHWs, CHW Supervisors, and other staff. The assumptions for costs of supervision visits are also input on this page. Note: the cost of supervision visits will be added to

the cost of staff supervision input on the "Supervision" worksheet; these will be added together to arrive at the total cost of supervision in the results.

1. Meetings

First, make a list of all relevant meetings relating to the iCCM program. These may typically include monthly meetings of the CHWs at the nearest health center, to deliver monthly reports and to re-stock on medicines. This can also include higher-level meetings to discuss iCCM or CHW programs at the district level. Select the administrative level where each meeting is held – the cost per meeting will then be multiplied by the number of each type of administrative level that is covered in the iCCM program.

Enter a description of the meeting, and then select the meeting attendees using the drop-down menu. If the meeting is for CHWs or CHW supervisors, the tool will automatically calculate the number of attendees. If the meeting is for "other", enter the number of participants in column I (the grey cells should be highlighted in yellow to indicate data entry, as in row 3 in the example below). Select whether the meeting is specific to iCCM or a general CHW program meeting using the drop-down menu in column F. Then enter the frequency of meetings per year and average meeting length in days.

	Administrative Level	Description of Meeting	Meeting Attendees	iCCM-Specific or General CHV Meeting	Frequency (Number Meetings per Year)	Length of meeting (average number of days)	Number of participants per meeting ("Other")
1	District	Quarterly commun	CHV supervisors	General	4	2	
2	Health Center	Monthly iCCM data	CHVs and CHV supe	iCCM	12	1	
3			Other				
4							

Next, input the assumptions for the meeting costs using the rubric provided in the tool and shown in the example below. Input the per diem, lodging, refreshment, and transportation cost per participant; then input the cost of fuel, stationery, and any other fixed costs per meeting.

Per diem cost (per participant per day)	Cost of lodging (per participant per day)	Transportation cost (per participant per meeting)	Cost of refreshments (per participant per day)	Cost of fuel (average cost per meeting)	Cost of stationary (average cost per meeting)	Other fixed meeting costs (average cost per meeting)	Non-participant cost per Meeting (CFA)	Cost per participant per Meeting (CFA)
1,000	250	500	250	-	-	10,000	8,000	2,800
500	-	-	250	-	-	-	-	750
							-	-
							-	-

The cost per participant and other meeting costs will be automatically calculated in columns Q and R.

2. Supervision Visits

To enter costs of supervision visits, follow the rubric in a similar manner as the example presented above for meetings. Typically, supervision visits will comprise visits from health center staff to villages to observe the CHWs in the field. List all relevant types of supervision visits, the frequency at which they take place, and whether the visit is intended to supervise iCCM specifically or the overall CHW activities.

The administrative level entered for the supervision visit should indicate the level from which the supervisions occur (i.e., if it is the District Health Officer, select "District" as the administrative level).

Training

All training costs should be input into the "Training" worksheet, comprising both start-up trainings and refresher trainings. The total cost of the start-up trainings will be added to the start-up iCCM program costs in the "Results" worksheets. The tool assumes that all new CHWs that are added to the program (either for purposes of scaling-up, or to replace CHWs lost to attrition) will undergo the start-up training.

The total cost of the refresher trainings will be part of the recurrent iCCM program costs. The tool assumes that all CHWs that are currently deployed will receive the refresher training, at the frequency indicated by the user.

1. Start-up training

First, make a list of all trainings related to start-up of the iCCM program. For example, these may include a Training of Trainers, then cascade trainings at the regional level, then initial training of CHWs at the district level.

Enter the administrative level where the training is held, then a description of the training, and then select the training attendees using the drop-down menu. If the meeting is for CHWs or CHW supervisors, the tool will automatically calculate the number of attendees. If the meeting is for "other", enter the number of participants in column I (the grey cells should be highlighted in yellow to indicate data entry, as in row 3 in the example below).

Select whether the training is specific to iCCM or a general CHW training using the drop-down menu in column F. Then enter the average length of training in days. The frequency is greyed out for the start-up training because it is assumed the training will occur once for each new CHW that enters the system. Enter the maximum number of trainees per session – the tool will automatically calculate the number of sessions that are required at each level of the health system.

	Administrative Level	Description of Training	Training Attendees	iCCM-Specific or General CHV Training	Frequency (Number Training Sessions per Year)	Length of training session (average number of days)	Maximum number of trainees per session
1	National	Training of Trainers	Other	General		5	15
2	Region	Cascade Training	CHV supervisors	General		5	25
3	District	Training of CHVs	CHVs	General		5	50
4							
5							
6							
7							
8							
9							
10							
11							
12							

Next, input the unit cost assumptions for the start-up training using the rubric provided in the tool. Transportation, per diem, and lodging costs are entered separately for training participants

and facilitators. Enter the cost of refreshments, room rental, stationary, training materials, and other fixed costs per training session. The tool will calculate the participant cost per training session, and the other fixed costs per training session.

2. Refresher training

For refresher trainings, follow the same methodology as that used for the start-up trainings above. Indicate the frequency of the refresher trainings per year.

Other Costs

The "Other Program Costs" worksheet allows the user to input any recurrent program costs that have not previously been addressed in the tool. Typically, these costs include administrative or overhead costs such as office rental, communications, or vehicle maintenance costs.

Indicate the administrative level at which the costs are incurred – the tool will automatically multiply the cost by the number of administrative levels covered by the iCCM program. Thus, if office running costs are input at the district level, the tool will assume that each district will incur the same running costs and multiply that cost by the number of districts.

1) Enter any other recurrent iCCM Program Costs in CFA	More Information

	Administrative Level	Description of iCCM Program Cost	Category	iCCM-Specific or General CHV Program Cost	Total Annual Cost per Administrative Level (CFA)
1	National	iCCM communication materials - printing costs	Communication materials	iCCM	1,247,500
2	National	Central office running costs	Overheads	General	2,500,000
3	Region	Vehicle maintenance	Infrastructure and other equipment	General	5,000,000
4	Region	Regional office running costs	Overheads	General	9,980,000

Enter a description of the iCCM program cost, the budget category where it would fall, and indicate whether the cost is specific to the iCCM program, or a general CHW program cost. Then input the total amount per administrative level per year. The total cost will be applied to each projection year of the program, in line with the assumptions input in the "Coverage" worksheet and with the inflation rate input in the "Program Info" worksheet applied.

Start-up

All start-up costs, other than those required for start-up training, should be entered in this worksheet. Typically, start-up costs are incurred before the program baseline year, but certain costs may continue throughout the program that would be considered as "start-up". Start-up costs may include baseline surveys, workshops, development of guidelines and training materials, or other technical assistance to get the iCCM program started up.

1) Enter all Start-Up Costs in CFA

	Description of Activity	Category	iCCM-Specific or General CHV Program Cost	Start-up Costs prior to 2013	2013
1	Baseline survey	Monitoring and evalua	iCCM		1,250,000
2	iCCM Policy workshop	Training	iCCM	500,000	
3	Development of training materials, registers, and supervision tools	Training	iCCM	980,000	
4	Technical Assisstance - Quality Assurance	Technical Assistance	General		2,500,000

Enter a description of the start-up activity, then select the budget category that matches the activity using the drop-down menu in column C. Indicate whether the activity is specific to iCCM or a general CHW program activity, then input the total cost as a fixed amount. All start-up costs incurred prior to the baseline year can be input in column F. Additional start-up costs can be input in the subsequent program years, if applicable.

Financing

The program financing can be entered in two ways in the tool: first, as a percentage of the iCCM program costs, as determined by the tool; and second, as a fixed amount of funding. The iCCM tool will then compare the estimated iCCM program costs with the anticipated funding to determine where any funding gaps may exist.

1. Funds as a % of total program costs

Funding is entered in this section as a percentage of total program costs, or a percentage of a specific iCCM program component. This section should be used for funding that is guaranteed to cover the costs of the program – for example, for government salaries that will be paid by the state, or for training costs that will be covered by a grant to an implementing NGO.

First, indicate the source of financing using the drop-down menu. If additional sources need to be added, make sure to add these on the "Program Info" worksheet – do not directly input into the "Financing" worksheet. Next, indicate the percentage of the iCCM program component that is funded by that source, and then select the component using the drop-down menu in column D. The main program components are denoted in broad categories such as medicines, CHW salaries, management, supervision, training, etc. Once a selection has been made, the total cost of that component will automatically be loaded into columns F-K, based on calculations in the tool.

1) To enter funds as a % OF PROGRAM COSTS: Enter Financing Sources, input % covered, and select iCCM Program Component in CFA *More Information*

	Source of Financing	% of iCCM Program Component Funded	iCCM Program Component	TOTAL FUNDING AMOUNT (CFA) 2013	2014	2015	2016	2017	2018
1	National government	20%	Management	14,088,871	14,511,537	14,962,796	15,411,680	15,874,031	16,350,252
2	NGO	80%	Management	56,355,483	58,046,147	59,851,186	61,646,721	63,496,123	65,401,006
3	UNICEF	100%	CHV Start-up Training Cost	89,455,800	31,642,365	33,357,554	35,725,416	38,051,742	40,472,056
4	NGO	25%	Supervision	103,765,250	119,612,131	132,984,848	146,361,850	158,309,896	170,776,666
5	NGO	100%	Training (Refresher)	24,293,750	30,583,438	37,139,594	43,829,448	50,637,416	57,758,389
6	National government	100%	CHV Start-up Equipment Co	248,819,890	32,601,572	40,202,115	37,254,140	47,748,157	44,215,223
7				-	-	-	-	-	-
8				-	-	-	-	-	-
9				-	-	-	-	-	-
10				-	-	-	-	-	-

2. Funds as a fixed amount

Funding is entered in this section as a fixed amount, without any direct link to the iCCM program costs. This section should be used for funds that are given as a fixed amount per year, and can relate to a specific iCCM program component (such as medicines or supervision), or can simply be a fixed amount that can be used towards any part of the program.

First, indicate the source of financing using the drop-down menu in column B. Then, enter the description of the funding and select the iCCM component that will be funded. If no specific component is known (i.e., the funds are not set aside for a specific part of the program), select "Total". Next, enter the amount of funding per financing source per program year.

2) To enter funds as a FIXED AMOUNT: Enter Source of Financing, Description, Amount, and iCCM Program Component in CFA | *More Information*

	Source of Financing	Description	iCCM Program Component	2013	2014	2015	2016	2017	2018
11	NGO	Workshops and training dev	iCCM Program Start-up Act	4,500,000					
12	UNICEF	ARI timers, antibiotics, ORS,	Medicines and Supplies	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000	150,000,000
13	Global Fund	RDTs, ACTs	Medicines and Supplies	200,000,000	250,000,000	300,000,000			
14									
15									
16									
17									
18									
19									
20									

The data entered in these two sections will be compiled to determine the total amount of funding available for the iCCM program, both as a total and by iCCM program component. This amount will then be compared with the total costs of the program to determine where any gaps in financing may occur.

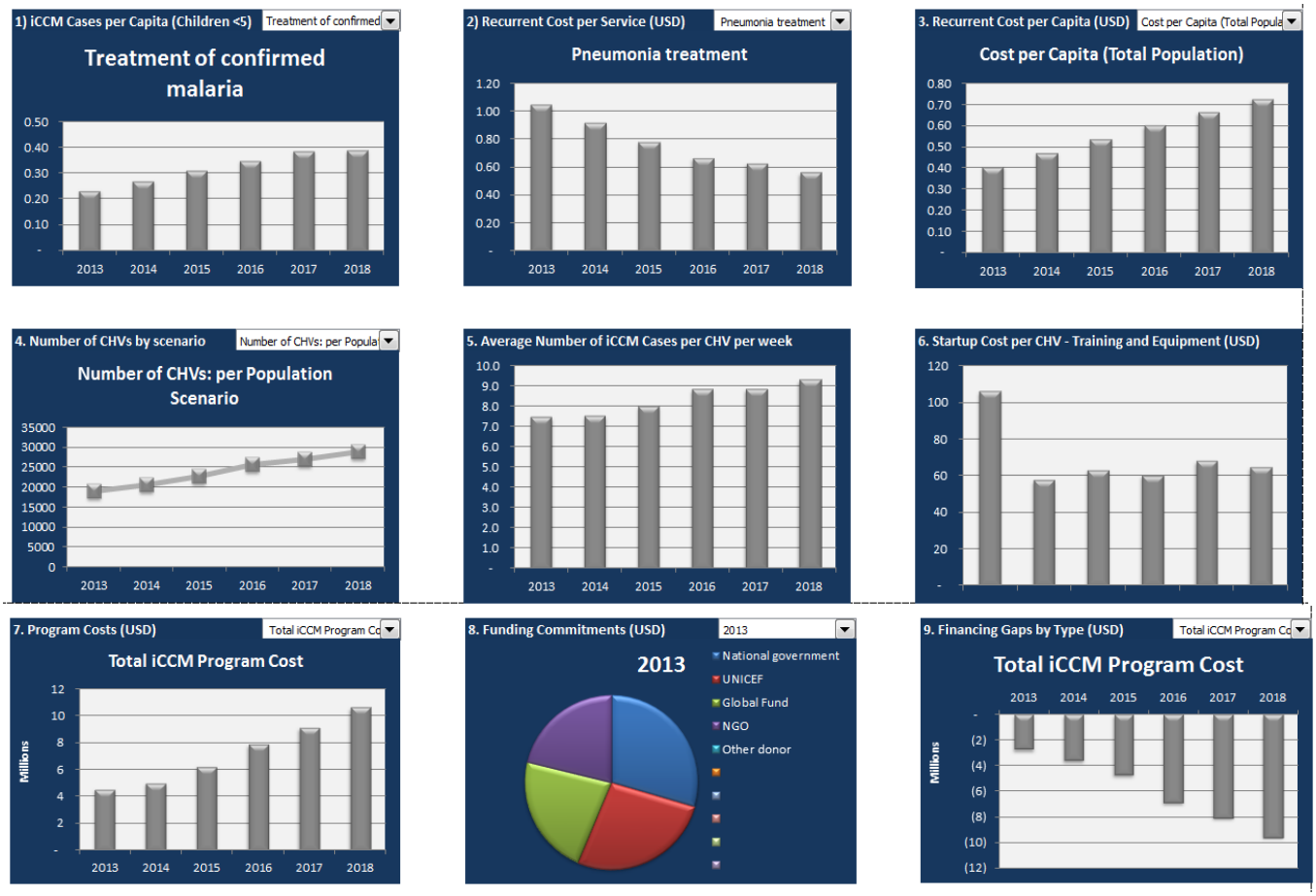
5. Results Worksheets

The "Results" worksheets display the results from the iCCM Costing and Financing Tool in a number of ways. First, the Dashboard provides a graphic summary of key indicators from the costing – cost per capita, cost per service, and services per capita. The Summary Table and Summary Graphs show the key results in greater detail, first in tabular format and second in graphic format. The Budget presents the iCCM program costs in a line-item budget format. Finally, the Policy worksheet orients the tool user to key policy questions that are asked when conducting a costing analysis, and where to find answers to these questions in the tool.

All results in the tool are automatically generated and do not require user input. Automatic conversion of the results from local currency into USD can be selected on the Dashboard. Any error messages in the results worksheets may indicate incorrect or insufficient data entered into the tool. **Note: do not change any formulas, add or delete rows or columns, or disrupt the results worksheets in any way.**

Dashboard

The Dashboard shows results from nine key indicators for the iCCM Costing and Financing analysis: cases per capita, cost per service, cost per capita, number of CHWs, number of iCCM cases per CHW per week, start-up cost per CHW, total program costs, funding commitments, and funding gaps. Toggle between local currency and USD using the drop-down menu in row 9.



Summary Tables

The summary tables show the detailed, comprehensive results of the costing and financing analysis. Each table shows the results by program year, and, where appropriate, totals or averages for the life of the program. The summary tables include the following:

- iCCM Program Coverage
- iCCM Caseloads
- CHW Numbers
- Summary of iCCM Program Costs
- Recurrent iCCM Program Costs by Category
- Recurrent iCCM Program Costs per Service
- Financing by Source
- Financing Gaps

The currency shown in the summary tables will be based on the selection made on the "Dashboard" worksheet, row 9.

Summary Graphs

The summary graphs show similar information contained in the summary tables, displayed in graphic format. Ensure that graphs are up to date by clicking on the "Update Graphs" button.

Budget

The iCCM program costs estimated by the tool are presented as a line-item budget using recognized budget categories (such as those found in Global Fund grants). Hover the mouse over the red comment triangles to see definitions of each budget category.

Currency:	*USD*

Line Item	2013	2014	2015	2016	2017	2018
Human resources	972,957	1,104,221	1,215,939	1,327,667	1,428,076	1,532,781
Technical Assistance	4,008	-	-	-	-	-
Training	230,921	124,701	141,277	159,429	177,734	196,855
Health products and health equipment	448,773	58,800	72,509	67,192	86,119	79,747
Medicines and pharmaceutical products	2,157,234	2,869,891	3,816,381	5,095,787	6,009,552	7,214,364
Procurement and supply management costs	289,556	325,410	432,099	573,664	677,297	810,457
Infrastructure and other equipment	96,192	106,814	117,906	129,486	141,571	145,110
Communication materials	2,500	2,563	2,627	2,692	2,760	2,829
Monitoring and evaluation	129,782	168,063	209,746	253,844	300,016	348,338
Living support to clients / target population	-	-	-	-	-	-
Planning and administration	-	-	-	-	-	-
Overheads	196,008	217,308	239,551	262,770	287,000	294,175
Other	-	-	-	-	-	-
TOTAL BUDGET	4,527,932	4,977,771	6,248,033	7,872,531	9,110,123	10,624,655

Policy Questions

A number of key policy questions are noted in this worksheet, which are typically asked as part of a costing analysis. These policy questions are as follows:

- How much will it cost, in total, to implement an iCCM program in the country?

- What is the incremental cost of scaling up an existing iCCM program?
- How much will it cost to add one or more services to the iCCM package?
- How many iCCM service providers (CHVs) are needed?
- What is the average number of cases that an iCCM service provider will manage?
- What percentage of expected iCCM cases will be treated through this iCCM Program?
- How is the program currently financed?
- How much will the financing gap be, if any, and for which resources?

These questions can all be answered using the iCCM Costing and Financing Tool, as indicated in the second column, "Where do I find the answers in this tool?".

6. Calculation Worksheets

The calculation worksheets provide the user with more in-depth figures that lead to the results displayed in the Results worksheets. All relevant results are shown in the previous worksheets; these worksheets do not need to be consulted and no user input is required. **Note: do not change any formulas, add or delete rows or columns, or disrupt the calculation worksheets in any way.**

Calculations - Services

This worksheet shows the calculations for the numbers of iCCM services per program year, services per capita, numbers of CHWs required per program year, and CHW training requirements.

Calculations – Total Cost

This worksheet shows the calculations for the total recurrent program costs by iCCM program component: Medicines and Supplies, CHW Salaries, Management, Supervision, Meetings, and Trainings. The recurrent cost breakdowns by health system level are also shown. Also, start-up costs are shown.

Calculations – Cost per Service

This worksheet shows the calculations for the recurrent cost per service, broken down by iCCM program component.

Calculations - Financing

This worksheet shows the calculations for the total financing by source, by iCCM program component, and the financing gaps.

7. Annex Worksheets

Annex A: Caseloads

Annex A: Caseloads is a blank spreadsheet that can be used to copy and paste caseload data. Where possible, numbers of iCCM services over several years should be collected, to establish a trendline and to document any variations with changes in policies (for example, if RDTs are introduced).

Annex B: Questionnaires

Annex B: Questionnaires includes the sample questionnaires shown in Annex C in this document. These questionnaires are illustrative only and should be modified for the country and program context.

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Annexes

Annex A. Data Collection Checklist

Annex B. Questionnaire Templates for Central and Partner Level

Annex C. Questionnaire Templates for District, Health Facility, and Community Level

Annex D. Glossary

Annex A. Data Checklist for iCCM Costing and Financing Tool

Type of Information
Country and iCCM Program Information
National population and sub-national population breakdown
% breakdown of population by age (newborns, infants, children <5, etc.)
Total population covered by the iCCM program
Geographic coverage of the iCCM program
National currency and exchange rate to USD
Annual inflation rate
Annual salary increase rate
iCCM Services
Services in iCCM package
Target population for each service in iCCM package
Target service delivery coverage for iCCM program
Standard treatment guidelines (drug dosages, etc.) for each service in iCCM package
Incidence rate (episodes per child per year) for each service in the iCCM package
Number of iCCM cases treated per program year
CHWs
Number of CHWs trained and deployed and providing iCCM services
Number of CHW supervisors trained and deployed
Standard CHW working hours, if applicable
CHW Salary, if applicable
Medicines & Equipment
List of standard equipment provided to CHW and costs
List of essential medicines provided to CHW and costs
Cost of supply, transport, management, and storage of medicines
Program Management
List of all staff involved in management of iCCM program
Salaries and % of time spent on iCCM program management
Supervision
List of all staff involved in supervision of CHWs providing iCCM
Salaries and % of time spent on iCCM supervision
Cost of supervision visits (transport, per diems, etc.)
Meetings
List of all meetings related to iCCM for CHWs, CHW Supervisors, and others
Cost of meetings (transport, per diems, facilitators, hall rentals, etc.)
Trainings
List of all trainings required for iCCM (TOTs, initial CHW training, etc.)
List of all refresher trainings required for CHWs and CHW Supervisors
Cost of trainings (transport, per diems, facilitators, hall rentals, etc.)
Program running costs
Administrative costs (office rental, communications, overheads)
Vehicle costs (fuel, maintenance, etc.)

Other recurrent program costs
Program start-up costs (not including training)
Baseline evaluations, policy development workshops, etc.
Program financing
Sources of financing for iCCM program
Amount of funding secured from each source
iCCM Program component that will be covered by each funder (i.e. medicines, training)

Annex B. Questionnaire Templates for Central and Partner Level

A. Program Information

1. National / Sub-National Information

1.1. What is the Country Name?

1.2. What is the Sub-National Name? (if doing a sub-national analysis)

1.3. What is the national currency?

1.4. What is the exchange rate to USD?

1.5. What is the average annual inflation rate (%)?

1.6. What is the average annual salary increase (%)?

1.7. What is the total National population (baseline year)?

1.8. What is the total Sub-National population (baseline year)? (if doing a sub-national analysis)

1.9. What proportion of the population is living in remote / hard to reach areas that will be covered by the iCCM Program (%)?

1.10. What is the annual population growth rate (%)?

1.11. What is the proportion of newborns (0-28 days old) as a % of total population?

1.12. What is the proportion of infants (0-12 months old) as a % of total population?

1.13. What is the proportion of children (2-59 months old) as a % of total population?

1.14. What is the proportion of children (0-59 months old) as a % of total population?

1.15. What is the proportion of pregnant women (as a % of total population)?

1.16. What is the date of this analysis?

2. List the Country Administrative Structures by Level:

2.1. First Level

2.2. Second Level

2.3. Third Level

2.4. Fourth Level

2.5. Fifth Level

2.6. Community Level

2.7. What is the average population size per Village?

3. Program Assumptions

3.1. What is the Baseline Program Year (start of calendar year)?

3.2. What is the Final Program Year (end of calendar year)?

3.3. How many different types of CHWs providing iCCM services?

3.4. Title and Abbreviation of Community Health Worker 1

3.5. Title and Abbreviation of Community Health Worker 2

3.6. Title of CHW Supervisor

4. List the Interventions Provided in iCCM Package?

5. List all the Sources of Financing for the iCCM Program?

B. Coverage

1. Geographic Coverage – for each program year, specify:

1.1. Number of National level with iCCM coverage

1.2. Number of Provinces with iCCM coverage

1.3. Number of Regions with iCCM coverage

1.4. Number of Districts with iCCM coverage

1.5. Number of Health Centers with iCCM coverage

1.6. Number of Villages providing iCCM

1.7. Total target population covered by iCCM Program (all ages)

1.8. Total Number of CHWs (Manual Input option)

1.9. Total Number of CHW2s (Manual Input option)

1.10. Total Number of CHW Supervisors (Manual Input option)

**NOTE: Above list is illustrative and will vary depending on user input into tool.*

2. Service Delivery Coverage – for each program year, specify:

2.1. Pneumonia treatment coverage as % of total expected cases

2.2. Diarrhea treatment coverage as % of total expected cases

2.3. RDT for fever cases coverage as % of total expected cases

2.4. Treatment of confirmed malaria coverage as % of total expected cases

2.5. Neonatal sepsis treatment coverage as % of total expected cases

**NOTE: Above list is illustrative and will vary depending on user input into tool.*

3. **Epidemiology Assumptions – enter the number of episodes per child per year:**

   3.1. Pneumonia treatment

   3.2. Diarrhea treatment

   3.3. RDT for fever cases

   3.4. Treatment of confirmed malaria

   3.5. Neonatal sepsis treatment

   **NOTE: Above list is illustrative and will vary depending on user input into tool.*

C. CHWs

1. **CHW Ratios and Availability**

   1.1. What is the desired ratio of CHWs per 1,000 Target Population?

   1.2. What is the desired ratio of CHWs per Village?

   1.3. What is the desired ratio of CHWs per Supervisor? (i.e. X number of CHWs per one supervisor)

   1.4. What is the CHW yearly Attrition Rate (%)?

   1.5. How many hours / week are available per person to work as a CHW?

   1.6. How many weeks / year are available per person to work as a CHW?

   1.7. How many hours / week are available per CHW to provide iCCM services?

2. **CHW Salary**

   2.1. Does the CHW receive any form of payment or incentive?

   2.2. If Yes, what is the total annual payment or incentive per CHW?

D. Medicines & Equipment

1. **CHW Medicines and Supplies**

   1.1. List the name of each medicine or supply provided to CHW

   1.2. List the unit and unit cost of each medicine or supply

   1.3. What is the % mark-up on medicines for transport, storage, management, and distribution?

2. **CHW Equipment**

   2.1. List the name of each equipment or material provided to each CHW

   2.2. List the unit, unit cost, and replacement frequency of each equipment or material

   2.3. What is the % mark-up on equipment for transport, storage, management, and distribution?

3. **CHW Supervisor Equipment**

3.1. List the name of each equipment or material provided to each CHW Supervisor

3.2. List the unit, unit cost, and replacement frequency of each equipment or material

E. Interventions

1. **For each intervention in the iCCM package:**

1.1. Time required for one full treatment including diagnosis and follow-up (mins)

1.2. List of medicine or supply required for each treatment

1.3. Number of times per day, number of days, and number of units per dose

1.4. % of cases that will receive each medicine

F. Management

1. **List each staff member involved in management of iCCM program**
2. **For each staff member:**

2.1. Administrative Level

2.2. Name/Title

2.3. Organization

2.4. Annual Salary

2.5. % of time spent on management of iCCM program for each program year

G. Supervision

1. **For direct CHW supervisor:**

1.1. Administrative Level

1.2. Annual Salary per Staff

1.3. % of time spent on supervision of iCCM program for each program year

2. **List all other staff involved in supervision of iCCM program**
3. **For each staff member:**

3.1. Administrative Level

3.2. Title

3.3. Number of staff per administrative level

3.4. Annual Salary

3.5. % of time spent on supervision iCCM program for each program year

H. Meetings

1. **List each meeting required for CHWs, CHW Supervisors, or other iCCM-related meetings**
2. **For each meeting:**
   - **2.1.** Administrative Level
   - **2.2.** Description of Meeting
   - **2.3.** Meeting Attendees (CHWs, CHW Supervisors, or other)
   - **2.4.** iCCM-Specific or General CHW Meeting
   - **2.5.** Frequency (Number Meetings per Year)
   - **2.6.** Length of meeting (average number of days)
   - **2.7.** Number of participants per meeting ("Other")
   - **2.8.** Per diem cost (per participant per day)
   - **2.9.** Cost of lodging (per participant per day)
   - **2.10.** Transportation cost (per participant per meeting)
   - **2.11.** Cost of refreshments (per participant per day)
   - **2.12.** Cost of fuel (average cost per meeting)
   - **2.13.** Cost of stationary (average cost per meeting)
   - **2.14.** Other fixed meeting costs (average cost per meeting)
3. **List each supervision visit required**
4. **For each supervision visit:**
   - **4.1.** Administrative Level
   - **4.2.** Description of Supervision Visit
   - **4.3.** iCCM-Specific or General CHW Supervision Visit
   - **4.4.** Frequency (Number Visits per Year)
   - **4.5.** Length of supervision visit (average number of days)
   - **4.6.** Number of supervisors per visit
   - **4.7.** Per diem cost (average per supervisor per day)
   - **4.8.** Number of support staff (e.g., driver) per supervision visit
   - **4.9.** Support staff per diem cost (average per staff per day)
   - **4.10.** Number of staff requiring lodging

4.11. Cost of lodging (per person per day)

4.12. Cost of fuel + lubricants (average cost per supervision visit)

4.13. Other fixed costs (average cost per supervision visit)

I. Training

1. **List each Start-up Training (such as Training of Trainers, initial training for CHWs, etc.)**
2. **For each Start-up Training:**

2.1. Administrative Level

2.2. Description of Training

2.3. Training Attendees

2.4. iCCM-Specific or General CHW Training

2.5. Length of training session (average number of days)

2.6. Maximum number of trainees per session

2.7. Per diem cost (per participant per day)

2.8. Transportation cost (per participant per session)

2.9. Lodging cost (per participant per day)

2.10. Number of facilitators per training session

2.11. Per diem cost (per facilitator per day)

2.12. Transportation cost (per facilitator per session)

2.13. Lodging cost (per facilitator per day)

2.14. Cost of refreshments (per person per day)

2.15. Room rental cost (per training day)

2.16. Cost of stationary (per training day)

2.17. Cost of training materials / guidelines (per participant)

2.18. Other fixed costs (average per training session)

3. **List each Refresher Training**
4. **For each Refresher Training:**

4.1. Frequency of training (sessions per year)

4.2. Refer to list for Start-up Training above

J. Other Costs

1. **List all recurrent iCCM program costs not accounted for elsewhere in the tool (i.e. administrative costs, office rental, communications, overheads)**
2. **For each recurrent program cost:**

   2.1. Administrative level where cost is incurred

   2.2. Description of cost

   2.3. Budget category

   2.4. iCCM-specific or general CHW program cost

   2.5. Total annual cost per administrative level

K. Start-up

1. **List all iCCM program start-up costs (not including start-up training)**
2. **For each start-up program cost:**

   2.1. Description of cost

   2.2. Budget category

   2.3. iCCM-specific or general CHW program cost

   2.4. Total cost per program year

L. Financing

1. **For funds entered as a % of total costs:**

   1.1. List the sources of funding

   1.2. Indicate the % of the iCCM program covered

   1.3. Select the iCCM component covered (i.e. medicines, training, meetings, supervision, etc.)

2. **For funds entered as a fixed amount:**

   2.1. List the sources of funding

   2.2. Enter a description of funding

   2.3. Select the iCCM component covered (i.e. medicines, training, meetings, supervision, etc.)

Annex C. Questionnaire Templates for District, Health Facility, and Community Level

Annex C1. District Level Questionnaire

Annex C2. Health Center Level Questionnaire

Annex C3. Community Level Questionnaire (for CHWs)

Annex C4. CHW Time Template

Annex C1. District Level Questionnaire

DISTRICT QUESTIONNAIRE		
Date of interview		
Name of interviewer		
Location of interview		
Name of district		
Name of person interviewed		
Title		
Contact information	**Phone Number**	
	Email	
What time did the interviewer begin this interview?		
Period of Analysis	**Start Date (MM/YY)**	
	End Date (MM/YY)	

	A. STAFF AND SUPERVISION	
1)	Which staff at the district level are involved with management or supervision of the iCCM Program?	
2)	For each of the staff listed, ask for the following:	
2a)	What is the title, the grade, and the years of service?	
2b)	What is the monthly salary (including benefits)?	
3)	What percentage of time is spent on iCCM management or supervision? If the staff member is unable to give a percentage, then prompt with the following questions:	
3a)	How many supervision visits does the staff member conduct per month?	
3b)	How many days does it take for each of the supervision visits (including travel)?	
3c)	How many days are spent on CHW or iCCM meetings, data validation, or other iCCM program activities?	
3d)	How many working days in total per month for the staff member?	
	Make the following calculation: [(3a + 3b + 3c) / 3d] = the percentage of time spent on iCCM	

	B. REPORTING, MEETINGS AND TRAINING	
1)	Describe the supervision structure for CHWs and for the iCCM Program in particular?	
2)	Describe the reporting mechanism for CHWs and for the iCCM Program in particular?	
3)	Describe the drug supply and management process for CHWs and for iCCM Program drugs?	

4)	Does the district office finance any trainings for CHWs or relating to the iCCM Program? If yes:	
	Fill out training worksheet in tool.	
5)	Does the district office finance any meetings for CHWs or relating to the iCCM Program? If yes:	
	Fill out meetings worksheet in tool.	
6)	What other activities relating to CHWs and iCCM are financed by the district?	

What time did the interviewer conclude the interview?	
How long (minutes/hours) was this interview?	

Annex C2. Health Center Questionnaire

HEALTH CENTER QUESTIONNAIRE		
Date of interview		
Name of interviewer		
Location of interview		
Name of district		
Name of health center		
Name of person interviewed		
Title		
Contact information	**Phone Number**	
	Email	
What time did the interviewer begin this interview?		
Period of Analysis	**Start Date (MM/YY)**	
	End Date (MM/YY)	

	A. STAFF AND SUPERVISION	
1)	Which staff at the health center are involved with management or supervision of the iCCM Program?	
2)	For each of the staff listed, ask for the following:	
2a)	What is the title, the grade, and the years of service?	
2b)	What is the monthly salary (including benefits)?	
3)	What percentage of time is spent on iCCM management or supervision? If the staff member is unable to give a percentage, then prompt with the following questions:	
3a)	How many supervision visits does the staff member conduct per month?	
3b)	How many days does it take for each of the supervision visits (including travel)?	
3c)	How many days are spent on CHW or iCCM meetings, data validation, or other iCCM program activities?	
3d)	How many working days in total per month for the staff member?	
	Make the following calculation: [(3a + 3b + 3c) / 3d] = the percentage of time spent on iCCM	

	B. REPORTING, MEETINGS AND TRAINING	
1)	Describe the supervision structure for CHWs and for the iCCM Program in particular?	
2)	Describe the reporting mechanism for CHWs and for the iCCM Program in particular?	

3)	Describe the drug supply and management process for CHWs and for iCCM Program drugs?	
4)	Does the health center finance any trainings for CHWs or relating to the iCCM Program? If yes:	
	Fill out training worksheet in tool.	
5)	Does the health center finance any meetings for CHWs or relating to the iCCM Program? If yes:	
	Fill out meetings worksheet in tool.	
6)	What other activities relating to CHWs and iCCM are financed by the health center?	

What time did the interviewer conclude the interview?	
How long (minutes/hours) was this interview?	

Annex C3. Community Level Questionnaire

COMMUNITY LEVEL QUESTIONNAIRE (FOR CHW)		
Date of interview		
Name of interviewer		
Location of interview		
Name of person interviewed		
Sex (M/F)		
Name of medical region		
Name of district		
Name of community		
Supervising Health Center		
Month/Year when CHW began providing iCCM services		
What time did the interviewer begin this interview?		
Period of Analysis	**Start Date (MM/YY)**	
	End Date (MM/YY)	

A) Catchment area served		
1)	What is the total population of the CHW's village or community?	
2)	How many households in the village?	
3)	Is there more than one CHW working in this village?	
3)	If yes:	
3a)	Do you divide the population between the CHWs, or cover the entire population but alternate?	
3b)	What is the total population served by the CHW?	
3c)	What are the total number of households covered by the CHW?	

B) CHW Time		
1)	In general, how many hours per day are you available to work as a CHW?	
2)	In general, how many days per week are you available to work as a CHW?	
3)	In general, do you work as a CHW all year, or are there days/months that you take off?	
Fill out Annex 4: CHW Time Template by asking the following questions:		
1)	Please list all the activities that are typically done as a CHW? (If they are not already listed in ANNEX 3 then add to the blank spaces, rows 18-21)	
2)	Was the last week a typical week for you as a CHW?	

	If yes, proceed with the following questions. If no, ask them to think of a 'typical' week in terms of their activities as a CHW.	
3)	List the different types of activities you did as a CHW in the previous week:	
3a)	How many hours did you take for each activity?	
3b)	For each activity, where did you go?	
3c)	For each activity, how long did it take to travel (i.e. to or from a household)?	
3d)	For each activity, was this specifically relating to iCCM, or just for CHW activities in general?	

C) Supervision and Reporting		
1)	With what frequency do you travel to the health center to give your reports or have data validation?	
2)	With what frequency do you fill out regular CHW or iCCM activity reports?	
3)	How many days per month do you spend filling out the monthly report?	
4)	With what frequency do you travel to the health center to re-stock on drugs and supplies?	
5)	How long does it take to go to the health center, and how far away is it?	
6)	Do you spend the whole day to go to the health center (round trip)?	
7)	When was the last time you received a supervision visit by your supervisor?	

D) Training/Meetings		
1)	Please make a list of the different trainings and meetings you had in the last year (2012).	
2)	For each training (fill out in the appropriate section if it's a meeting or a start-up or refresher training)	
2a)	Who was the meeting or training funded by? (if the CHW doesn't know, leave blank)	
2b)	Where was the meeting or training held?	
2c)	How frequent is the meeting or training (if refresher)?	
2d)	How long was the meeting or training?	
2e)	Was the CHW paid a per diem or incentive? If yes, how much?	

E) iCCM Services		
1)	What iCCM treatments are you able to provide now?	
1a)	Were you providing the same treatments in 2012?	
2)	For each iCCM service, list the approximate amount of time that is required to provide the treatment:	
2a)	Diarrhea	
	Treatment	
	Follow-up	

2b)	Pneumonia	
	Treatment	
	Follow-up	
2c)	Malaria	
	Treatment	
	Follow-up	
2d)	Referrals	
	Treatment	
	Follow-up	
2e)	(Other treatment, if provided)	
	Treatment	
	Follow-up	
3)	When a patient is referred to the health center, do you record the patient in your register?	
3a)	Do you receive a counter-reference from the health center?	
3b)	Do you accompany the patients to the health center?	
3c)	Do you provide an initial treatment to the patient before referring them?	
4)	For fevers, do you give a Rapid Diagnostic Test (RDT) to confirm malaria?	
4a)	If the RDT is negative, what do you do? Do you provide any treatment?	
4b)	If the RDT is negative, how do you record the patient in your register?	
5)	How do you test to make a diagnosis for pneumonia?	
5a)	If the test is negative, what do you do? Do you provide any treatment?	
5b)	If the test is negative, how do you record the patient in your register?	

F) Periodic CHW activities		
1)	Do you participate in additional periodic events, such as vaccination campaigns, bednet distributions, etc?	
2)	List each event, length of time, frequency,etc.	

G) Medicines, supplies and equipment			
1)	**For the following drugs, did you receive the drug each month of the last quarter, and did you have any stockouts?**	**Received (yes/no)**	**Stockouts (yes/no)**
a)	Zinc		
b)	ORS		
c)	Cotrimoxazole		
d)	RDT		
e)	ACT		

2)	Did you receive these supplies when you began your work as a CHW?	Received (yes/no)
a)	Drug box	
b)	Timer	
c)	MUAC tape	
d)	Scale	
e)	Other?	

H) Fees for service and incentives		
1)	Do you receive any forms of payment for your services as a CHW?	
1a)	If yes, from what source is the payment, and how much?	
2)	Do you receive any incentives "in kind" for your services as a CHW?	
2a)	If yes, from what source is the incentive, and how much?	

What time did the interviewer conclude the interview?	
How long (minutes/hours) was this interview?	

Annex C4. CHW Time Template

Ask CHW how many hours he or she spent on each of the activities below for every day in the past week.

CHW Name:		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1)	iCCM							
1a)	treatment provided at the CHW household							
1b)	treatment or follow up at the patient's household							
2)	Other healthcare services provided (Nutrition, family planning, TB, etc.)							
2a)	treatment provided at the CHW household							
2b)	treatment or follow up at the patient's household							
3)	Health promotion activities: village talks, household visits							
4)	Supervision meetings							
5)	Meetings at the health center							
6)	Meetings at the district							
7)	Any other CHW or iCCM related meetings							
8)	Monthly reporting							
9)	Other activities as a CHW:							
9a)	1)							
9b)	2)							
9c)	3)							
9d)	4)							
10)	Working for livelihood (farming, etc.)							

Annex D. Glossary

Capital expenditure:	The cost for resources that last more than one year, such as building, vehicles, computers, pre-service training. Sometime a price ceiling is also defined (usually $US100), below which costs are considered as recurrent. The cost of capital equipment is net of depreciation. Also called investment or non-recurrent cost/expenditure.
Community health worker	Any health affiliated worker (paid, unpaid, skilled birth attendants, etc.) that provides health care at the ground level.
Cost benefit analysis:	A comparison of costs and achieved benefits, where both costs and benefits are expressed in monetary terms.
Cost effectiveness analysis:	A form of economic evaluation where costs are expressed in money terms but consequences are expressed in physical units. It is used to compare different ways of achieving the same objective.
Costing:	(i) the estimation of a specific strategy or intervention, or of an overall national policy, strategy or plan. (ii) the estimation of the cost of different scenarios, corresponding to different priorities or strategies, in the short, medium or long term.
Direct cost:	(i) internal cost of an activity or decision including cost of labor, other goods and services, capital (usually considered as a rental value) and consumables. Direct cost excludes external costs, productivity costs, uncompensated forgone earnings and elements of cost that may be undervalued by market prices.42 (ii) all the goods, services and other resources that are consumed in the provision of a particular service or area (e.g. hospital supplies), including medical costs (e.g. payments to providers, material) and non-medical costs (e.g. transportation to hospital).
Depreciation:	The reduction in value of a capital asset through wear and tear.
Economies of Scale:	The decline in average cost of each unit produced as output increases, due to the distribution of production costs and other fixed costs across a higher number of units.
Fixed cost:	A cost that does not change with variations in output. For example, the rent of a clinic building does not change with the number of patients treated (until the capacity of the clinic is reached.
Geographic coverage:	The coverage of a program, in terms of geographic areas: number of provinces, regions, districts covered; as well as structures such as health centers supervising the program.
Incidence rate:	The number of new cases per population at risk at a given time.
Indirect costs:	Total sum of morbidity costs (goods and services not produced by the patient because of the illness), mortality costs (goods and services the person could have produced had the illness not been incurred and the person not died prematurely), and productivity cost (related to lost productivity incurred by an

	employee who leaves work to provide care for the patient).
iCCM percent attribution:	The percentage of a general shared CHW program cost that will be allocated specifically to the iCCM program; in the tool, this is based on the proportion of a CHW's time spent on iCCM versus all other CHW activities.
Marginal cost:	The change in total cost that results from a unit increase in output.
Opportunity cost:	"The value of the next best alternative forgone as a result of the decision made."
Prevalence rate:	The proportion of people in a population who have a particular disease at a specified point in time.
Recurrent expenditures – costs:	Costs that refer to inputs which last less than one year and are regularly purchased for continuing an activity, such as salaries, drugs and supplies, repair maintenance, and others.
Variable cost:	A cost that is directly proportional to the number of outputs produced. For example, in a clinic the cost of drugs can be regarded as varying directly with the number of patients treated.
Semi-Variable Cost:	A cost which has a fixed element and a variable element and which varies to some degree with the volume of outputs produced. An example would be the cost of a training course which has a fixed element (the rent of the room) and a variable element (materials for the students).
Service delivery coverage:	The coverage of a program, with regards to the proportion of services delivered at the community level through iCCM versus other levels of the health system (such as health center).
Start-up cost:	A onetime cost, usually at the beginning of the program and usually a larger sum of money. For example: the purchase of a vehicle, buying office space, and furniture
Step-variable cost:	A cost which is fixed up to a certain volume of outputs. An example would be a nurse at a clinic who can see up to 30 patients per day. Her salary is a fixed cost when the volume is up to 30 patients. When there are 31 patients another nurse has to be hired and the salary cost increases to that of two nurses. Presented graphically these costs look like steps.

Source: World Health Organization - Health Systems Strengthening Glossary: http://www.who.int/healthsystems/Glossary_January2011.pdf

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